

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395621	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER St Mary Center for Rehabilitation & Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 701 Lansdale Avenue Lansdale, PA 19446	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on policy review, observation, and staff interview, it was determined that the facility failed to properly store food and maintain sanitary conditions in the dietary department. Findings include: Review of the facility's policy entitled, Labeling and Dating Food, dated June 9, 2025, revealed that prepared foods that were held at 41 degrees Fahrenheit or lower were to be discarded after seven days. Observations during the tour of the dietary department on December 16, 2025, at 10:30 a.m., revealed the following: In the juice box, there were two cups of prepackaged water that were directly touching apples in a bowl. In walk- in cooler 1, there was an opened large package of potato salad not dated. In walk-in cooler 2, there was a crinkled piece of wax paper between the food shelf and wall. The reach-in cooler had dried food debris on the outside of it. On the inside of the door there was a large area of a white dried liquid splattered along the length of it and there was white dried liquid along the inside bottom of the cooler. There was a pan of applesauce dated December 4, 2025. In the closet, there was a mop in a bucket with dirty water, not in current use. The mop wringer had a thick dark substance along all the holes of it. A shelf at the juice dispenser had a dried sticky substance on it below the dispenser area. CFR 483.60(i) Food Safety Requirement Previously cited 1/24/25 28 Pa. Code 201.14(a) Responsibility of licensee.		

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and resident and staff interview, it was determined that the facility failed to ensure that a resident had a call bell accessible to request assistance from staff for four of 24 sampled residents. (Resident 30, 68, 74, 102) Findings include: Clinical record review revealed that Resident 30 had diagnoses that included dementia, cerebral infarction, acute respiratory failure and cataracts in both eyes. Review of the Minimum Data Set assessment (MDS), dated [DATE], revealed that Resident 30 was able to make her needs known, required some assistance with activities of daily living and was at risk for falls. Resident 30's most recent care plan revealed the resident had a potential for falls and directed staff to ensure that Resident 30's call bell was within easy reach and to reinforce the need to use the call bell for assistance. Observations on December 16, 2025, at 11:17 a.m., revealed that Resident 30 was in bed and the call bell was on the floor under the bed out of reach. Subsequent observations on December 17, 2025, at 9:20 a.m., and December 18, 2025, 10:55 a.m., revealed the call bell was clipped to the sheet close to the floor and out of reach. During interviews on these dates and times, Resident 30 stated she did not know where the call bell was. Clinical record review revealed that Resident 68 had diagnoses that included dementia, and muscle wasting. Review of the MDS assessment dated [DATE], revealed that Resident 68 was able to make her needs known, was dependent on staff for assistance with activities of daily living and was at risk for falls. Resident 68's most recent care plan revealed the resident had a potential for falls and directed staff to ensure that Resident 68's call bell was within easy reach. Observations on December 16, 2025, at 11:27 a.m., revealed that Resident 68 was in bed and the call bell was on the floor under the bed out of reach. Subsequent observations on December 17, 2025, at 9:32 a.m., and December 18, 2025, 11:00 a.m., revealed the resident was in bed and the call bell was clipped to the sheet close to the floor and out of reach. During interviews on these dates and times, Resident 68 stated she did not know where the call bell was. Clinical record review revealed that Resident 74 had diagnoses that included anxiety, muscle wasting, and diabetes. Review of the MDS assessment dated [DATE], revealed that Resident 74 was able to make her needs known, required assistance from staff for activities of daily living and was at risk for falls. Resident 74's most recent care plan revealed the resident had a potential for falls and directed staff to ensure that Resident 74's call bell was within easy reach and to reinforce the need to use the call bell for assistance. Observations on December 18, 2025, at 10:57 a.m., 11:47 a.m., and 12:15 p.m., revealed that Resident 74 was in bed and the call bell was clipped to the sheet at the very top of the bed out of reach. During an interview on December 18, 2025, at 12:15 p.m., the resident stated she uses the call bell but did not know where it was. Clinical record review revealed that Resident 102 had diagnoses that included dementia, cataracts, and irritable bowel syndrome with diarrhea. Review of the MDS assessment dated [DATE], revealed that Resident 102 was able to make his needs known, required assistance from staff for activities of daily living and was at risk for falls. Resident 102's most recent care plan revealed the resident had a potential for falls and directed staff to ensure that Resident 102's call bell was within easy reach. Observations on December 16, 2025, at 11:00 a.m., and December 17, 2025, at 10:30 a.m., revealed that Resident 102 was in bed and the call bell was clipped to the metal bed frame at the top of the bed facing the floor out of reach. During an interview on December 19, 2025, at 9:30 a.m., the Director of Nursing stated the call bells should have been within reach of each resident. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and resident interview, it was determined that the facility failed to provide activities in accordance with resident preferences and choice for one of 24 sampled residents. (Resident 6) Findings include: Clinical record review revealed that Resident 6 had diagnoses that included muscle weakness and anxiety. The Minimum Data Set assessment dated [DATE], indicated that the resident was alert and oriented. The assessment also indicated that it was very important for her to attend church; to do things with groups of people, the resident used a wheelchair and was dependent on staff for care. In an interview on December 17, 2025, at 10:40 a.m., Resident 6 expressed a concern that she could not attend church services on Sunday, Monday, and Tuesday at 11:00 a.m., because staff did not wake her up early. Resident 6 was observed in a gown and was upset and anxious and stated that attending church was very important to her, and that she had told staff that she preferred to be dressed before 9:00 a.m., to attend church. Review of the December 2025 activities calendar revealed that church services were scheduled every day at 11:00 a.m. A review of the care plan revealed an area for activities that indicated the resident's religion was important to her and staff was to assist the resident to religious services. Review of an activity assessment dated [DATE], revealed that Resident 6 actively attended church services and enjoyed many group activities. The goal was for her to maintain her current level of participation in preferred leisure interests. In an interview on December 19, 2025, at 9:30 a.m., the Director of Nursing confirmed that Resident 6 preferred to be dressed early and attending church was important. 28 Pa. Code 211.12(d)(3) Nursing services.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the Minimum Data Set (MDS) assessment was completed to accurately reflect the current status of three of 24 sampled residents. (Residents 1, 9, and 23) Findings include: Clinical record review revealed that Resident 1 received oxygen therapy starting on November 30, 2025. The MDS assessment dated [DATE], incorrectly indicated in Section O (Special treatments, Procedures, Programs) that the resident was not receiving oxygen therapy during the previous seven days. Clinical record review revealed that Resident 9 had diagnoses that included schizophrenia. Review of the physician's orders revealed that Resident 9 had been receiving an antipsychotic medication, olanzapine, since August 30, 2025. Review of the October 2025 medication administration record revealed that Resident 9 received olanzapine during the MDS review period. The MDS assessment dated [DATE], revealed that section N (Medications) incorrectly indicated that the resident did not receive an antipsychotic medication in the review period. Clinical record review revealed that Resident 23 received hospice services starting on April 24, 2024. The MDS assessment dated [DATE], incorrectly indicated in Section O (Special treatments, Procedures, Programs) that the resident was not receiving hospice services during the previous seven days. In an interview on December 16, 2025, at 9:27 a.m., the Administrator confirmed that Resident 1, 9, and 23's MDS assessments were inaccurate.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on clinical record review and staff interview, it was determined that the facility failed to review the care plan within seven days after the completion of the comprehensive assessment for three of 24 sampled residents. (Residents 5, 30, 68) Findings include: Clinical record review revealed that Resident 5 had a quarterly Minimum Data Set (MDS) assessment completed on February 11, 2025, an annual MDS assessment completed on May 12, 2025, a quarterly MDS assessment completed on August 6, 2025, and a quarterly MDS assessment completed on November 6, 2025. There was a lack of documentation to support that the facility had conducted an interdisciplinary care plan meeting to review the care plan within the required timeframe. Clinical record review revealed that Resident 30 had a quarterly MDS assessment completed on April 15, 2025, a quarterly MDS assessment completed on July 23, 2025, a quarterly MDS assessment completed on August 15, 2025, and an annual MDS assessment completed on November 14, 2025. There was a lack of documentation to support that the facility had conducted an interdisciplinary care plan meeting to review the care plan within the required timeframe. Clinical record review revealed that Resident 68 had a quarterly MDS assessment completed on June 4, 2025, an annual MDS assessment completed on August 29, 2025, and a significant change MDS assessment completed on November 15, 2025. There was a lack of documentation to support that the facility had conducted an interdisciplinary care plan meeting to review the care plan within the required timeframe. In an interview on December 19, 2025, at 12:12 p.m., the Administrator confirmed that there was no documentation that interdisciplinary care conferences were conducted after the completion of the comprehensive assessments to review the care plans for Residents 5, 30 and 68. 28 Pa. Code 201.18(b)(3) Management.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to implement physicians' orders for two of 24 sampled residents. (Resident 14, 32) Findings include: Clinical record review revealed that Resident 14 had diagnoses that included dementia and anxiety. A physician's order dated June 5, 2025, directed staff to administer a medication (midodrine hydrochloride) twice a day for hypotension (low blood pressure). Staff was not to administer the medication if the resident's systolic blood pressure (SBP, the first measurement of blood pressure when the heart beats and the pressure is at its highest) was greater than 130 millimeters mercury (mm/Hg) or higher. Review of Resident 14's Medication Administration Record revealed that staff withheld the medication when the resident's SBP was below 130 mm/Hg on three occasions in October 2025, 14 occasions in November 2025, and 10 occasions in December 2025. There was no documented evidence that the physician had instructed staff to hold the medication. In an interview on December 19, 2025, at 2:03 p.m., the Director of Nursing confirmed the medication should have been administered and there was no documented evidence the physician instructed staff to hold the medication. Clinical record review revealed that Resident 32 was admitted on [DATE], and had diagnoses that included hypertension (high blood pressure) and congestive heart failure. On November 15, 2025, a physician ordered that staff weigh the resident every day. A review of Resident 32's weights revealed that there was no documented evidence to support that staff weighed the resident on November 23 and 29, 2025, and December 2 and 11, 2025. In an interview on December 19, 2025, at 11:04 a.m., the Director of Nursing confirmed there was no documented evidence to support that staff weighed the resident in accordance with the physician's order. CFR(s) 483.25 Quality of Care Previously cited 1/24/25 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to provide restorative nursing services to prevent a reduction in range of motion and/or to improve or maintain mobility on a consistent basis for one of 24 sampled residents. (Resident 112) Findings include: Clinical record review revealed that Resident 112 had diagnoses that included muscle wasting and a history of falling. The Minimum Data Set assessment dated [DATE], indicated that the resident was cognitively impaired and required staff assistance for activities of daily living. Review of the physical therapy Discharge summary dated [DATE], revealed that the resident required staff assistance for transfers and ambulation. The physical therapist recommended a restorative nursing program for Resident 112 and documented that training and instruction was provided to the resident and primary caregivers. A restorative recommendation document dated November 10, 2025, indicated that the resident would benefit from an ambulation program. Staff was to assist the resident to walk 90 feet or less with a walker while staff followed with a wheelchair three times a week. Documentation indicated that nursing staff on 300 hallway (the resident's home) were educated regarding the functional maintenance/restorative nursing program to be provided. Review of nursing documentation from November 20, 2025, through December 19, 2025, revealed there was a lack of documentation to support that the resident received restorative nursing services. In an interview December 19, 2025, at 2:04 p.m., the Director of Nursing confirmed that there was no documentation to support the resident was ambulated as recommended by the physical therapist at discharge from therapy services. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined that the facility failed to implement safety interventions for three of five sampled residents at risk for falls. (Residents 68, 98, 112) Findings include: Clinical record review revealed that Resident 68 had diagnoses that included dementia, and muscle wasting. Review of the resident's Minimum Data Set (MDS) assessment dated [DATE], revealed that the resident was cognitively impaired and required staff assistance for bed mobility and transfers. Review of the Care Area assessment dated [DATE], revealed that Resident 68 was at risk for falls. Review of the resident's care plan revealed that the resident had fall interventions to have their bed in the lowest position to the floor and fall mats in place on each side of the bed while the resident was in bed. Observations on December 16, 2025, at 11:27 a.m., revealed that Resident 68 was in bed and there were no fall mats on the floor. Subsequent observations on December 17, 2025, at 9:32 a.m., and December 18, 2025, at 11:00 a.m., 12:51 p.m., and 1:15 p.m., revealed the resident was in bed and there were no fall mats on the floor beside the bed. Additionally on these dates and times the resident was observed to be in bed and the bed was not in the lowest position to the floor as care planned. On December 18, 2025, at 12:51 p.m., a nurse aide (NA 2) was observed raising the bed into a higher position. During an interview on December 18, 2025, at 12:51 p.m., NA 2 stated that she placed the bed in the higher position and was not aware that the resident should have fall mats on each side of the bed. Clinical record review revealed that Resident 98 had diagnoses that included seizures and left side weakness or paralysis of the left side due to a stroke. A review of Resident 98's MDS assessment, dated November 27, 2025, indicated that the resident was cognitively impaired and required staff assistance for bed mobility and transfers. A review of Resident 98's fall assessment, completed on November 27, 2025, indicated that the resident was at risk for falls. A review of the resident's care plan indicated that Resident 98 was to have fall mats in place on the floor when the resident was in bed. Observations on December 16, 2025, at 11:45 a.m., and December 19, 2025, at 10:05 a.m., revealed that Resident 98 was in bed with one fall mat on the floor on the right side of the bed and another fall mat against the wall on the right side of the bed. Clinical record review revealed that Resident 112 had diagnoses that included dementia, and muscle wasting. Review of the resident's MDS assessment dated [DATE], revealed that the resident was cognitively impaired and required staff assistance for bed mobility and transfers. Review of the Care Area assessment dated [DATE], revealed that Resident 112 was at risk for falls. Review of the resident's care plan revealed that the resident had fall interventions to have the bed in the lowest position and fall mats in place while the resident was in bed. Observations on December 16, 2025, at 11:00 a.m., revealed that Resident 112 was in bed and there was a fall mat on the right side of the bed on the floor folded in half. There was no fall mat on the other side of the bed. Subsequent observations on December 16, 2025, at 11:30 a.m., found the resident in bed and the folded fall mat on the floor and December 17, 2025, 10:30 a.m., revealed the resident was in bed and one fall mat was on the floor on the right side of the bed. There was no second fall mat on the floor during these observations. Additionally on these dates and times the bed was not in the lowest position to the floor as care planned. In an interview on December 19, 2025, at 9:49 a.m. and 11:00 a.m., the Director of Nursing confirmed that the fall mats should have been in place on both sides of the bed for Residents 68, 98, and 112, and that the beds should have been in the lowest position to the floor while Residents 68 and 112 were in bed. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and resident interviews, it was determined that the facility failed to accommodate food preferences for one of 24 sampled residents. (Resident 9) Findings include: Review of the facility's weekly menu revealed that the lunch meal for December 16, 2025, was herb rubbed pork loin with gravy, boiled new potatoes, brussels sprouts, and glazed pear cobbler. Clinical record review revealed that Resident 9 was admitted to the facility with diagnoses that included anxiety, gastroesophageal reflux disease (GERD), and depression. A Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident was alert and able to make his needs known. During an interview on December 16, 2025, at 12:15 p.m. Resident 9 stated that his meals did not match what was on his ticket and he did not receive foods he liked that were listed on the meal ticket. On December 16, 2025, at 12:20 p.m., his lunch tray was observed on his bedside table and had herb rubbed pork loin, brussels sprouts, and boiled new potatoes. There was no gravy served on the resident's meat. Resident 9 stated that he wanted gravy for the meat as listed on the meal ticket and did not have it. He did not want to eat the meat without the gravy as listed on his ticket. The resident's tray card indicated that the resident was on a regular diet and was to get gravy at the meal. In an interview on December 18, 2025, at 2:15 p.m., the Administrator stated that the dietary department did not follow Resident 9's meal ticket and they should have provided the gravy. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b) Management.		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that adaptive equipment was provided to one of 24 sampled residents. (Resident 15) Findings include: Clinical record review revealed that Resident 15 had diagnoses that included a stroke, difficulty swallowing food or liquids, and dementia. A review of Resident 15's Minimum Data Set, dated [DATE], indicated that Resident 15 was cognitively impaired. A review of Resident 15's speech therapy Discharge summary, dated [DATE], revealed that the resident was to utilize a dysphagia cup (a specialized cup that restricts liquids to small sips) for drinking liquids. A review of Resident 15's meal ticket revealed that the resident was to receive two large green dysphagia cups with meals. Observations on December 16, 2025, between 12:30 p.m. and 12:45 p.m., December 17, 2025, between 12:30 p.m. and 12:45 p.m., and December 18, 2025, between 12:35 p.m. and 12:50 p.m., revealed that only one green dysphagia cup was on Resident 15's lunch tray. During the observation on December 18, 2025, Resident 15 was assisted by a Nursing Assistant (NA 1) drinking milk from the dysphagia cup. Resident 15 reached for the dysphagia cup when it was brought to her mouth, and she held the handle while drinking the milk. An unopened juice cup and an unopened cup of coffee were also on the tray and not in an adaptive cup. In an interview on December 18, 2025, at 12:45 p.m., NA 1 stated that two green dysphagia cups were supposed to be on Resident 15's meal tray, but only one cup was received from the kitchen. In an interview on December 19, 2025, at 10:20 a.m., the registered dietitian confirmed that two green dysphagia cups should have been on each meal tray for Resident 15's different liquids. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, observations, and staff interviews, it was determined that the facility failed to follow policies and procedures to prevent the spread of infection for one of 24 sampled residents. (Resident 6) Findings include: Review of the facility policy entitled, Enhanced Barrier Precautions, last reviewed on June 9, 2025, revealed that staff was to wear a gown and gloves during high contact resident care activities such as transferring from the bed to chair and back to prevent infections. Review of clinical record revealed that Resident 6 was admitted to the facility on [DATE], with a diagnosis that included dysphagia (difficulty swallowing) and muscle weakness. Review of the Minimum Data Set assessment dated [DATE], revealed that Resident 6 had an enteral feeding tube (a soft plastic tube inserted into the digestive system used to provide nutrition directly through the stomach.) Review of the care plan revealed that Resident 6 required Enhanced Barrier Precautions and called for staff to wear gloves and gowns during close contact interactions. Observation on December 16, 2025, at 12:40 p.m., a registered nurse (RN 1) and a nurse aide (NA 3) transferred Resident 6 with a mechanical device from the bed to the wheelchair. RN 1 and NA 3 did not wear gloves and gowns during the transfer. At the time of the observation, RN1 stated that she should have worn a gown and gloves as she transferred Resident 6 from the bed to the wheelchair. In an interview on December 19, 2025, at 9:30 a.m., the Director of Nursing confirmed that staff should have worn gloves and a gown during the transfer. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395621	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER St Mary Center for Rehabilitation & Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 701 Lansdale Avenue Lansdale, PA 19446	
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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, it was determined that the facility failed to provide a safe, sanitary, and comfortable environment on two of four nursing units. (St. [NAME] and St. [NAME]) Findings include: Observation throughout the facility December 16 to 18, 2025, from 10:00 a.m. to 2:00 p.m., revealed the following: A lift (used to transfer residents from surface to surface) was observed to have dirty wheels with knotted/intertwined thick [NAME] of hair and debris. Three medication carts were observed to have dirty wheels with knotted/intertwined thick [NAME] of hair and debris. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(3) Management.		

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Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395621	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER St Mary Center for Rehabilitation & Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 701 Lansdale Avenue Lansdale, PA 19446	
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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and staff interview, it was determined that the facility failed to post accurate and current nurse staffing information. Findings include: Observations during a tour of the facility conducted December 16 through 18, 2025, between 9:30 a.m., and 2:00 p.m., revealed there was no staffing data posted. In an interview on December 18, 2025, at 2:25 p.m., the Administrator confirmed that there was no staffing data posted in the facility. 28 Pa Code 201.18(b)(3) Management.		