

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: 395697	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Embassy of Woodland Park		STREET ADDRESS, CITY, STATE, ZIP CODE 18889 Croghan Pike Orbisonia, PA 17243	
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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to inform the resident and/or resident representative in advance of the risks and benefits of psychotropic medication (medications that affect the persons mental state, emotions and behavior) use and the treatment alternatives prior to initiating the administration of the medication for five of 35 residents reviewed (Residents 8, 10, 11, 19 and 68). Findings Include: The facility's policy regarding the use of psychotropic medications, dated March 13, 2025, indicated that prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medications, including any black box warnings for antipsychotic medications, in advance of such initiation or increase. The facility would document that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and the preferred option to accept or decline in a format the facility deems to use (e.g., written consent form, narrative note, etc.).A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated October 8, 2025, revealed that the resident was cognitively impaired, received antipsychotic medications (a psychotropic medication), and had diagnoses that included dementia, post traumatic stress syndrome, and anxiety.Physician's orders for Resident 8, dated February 17, 2023, included an order for the resident to receive 25 milligrams (mg) of Cymbalta (an antidepressant medication) twice a day. Physician's orders for Resident 8, dated July 19, 2025, included an order for the resident to receive 25 mg of Cymbalta three times a day. There was no documented evidence in Resident 8's clinical record that the resident's representative was informed in advance of the risks and benefits and treatment alternatives prior to increasing the dose of Cymbalta.Interview with the Director of Nursing on December 4, 2025, at 1:31 p.m. confirmed that there was no documented evidence in Resident 8's clinical record that the resident's representative was informed in advance of the risks and benefits and treatment alternatives prior to increasing the dose of Cymbalta.A quarterly MDS assessment for Resident 10, dated October 14, 2025, revealed that the resident was cognitively impaired, received antipsychotic and antianxiety (psychotropic medication), and had diagnoses that included dementia.Physician's orders for Resident 10, dated June 2, 2025, included an order for the resident to receive 0.25 mg of lorazepam (an antianxiety medication) once daily for generalized anxiety. Physician's orders for Resident 10, dated November 4, 2025, included an order for the resident to receive 0.5 mg of lorazepam twice daily for generalized anxiety.There was no documented evidence in Resident 10's clinical record that the resident's representative was informed in advance of the risks and benefits and treatment alternatives prior to initiating an increased dose of lorazepam.Interview with the Director of Nursing on December 4, 2025, at 11:01 a.m. confirmed that there was no documented evidence in the Resident 10's clinical record that the resident's representative was informed in advance of the risks and benefits and treatment alternatives prior to increasing lorazepam.An admission MDS assessment for Resident 11, dated October 14, 2025, revealed that the resident was cognitively impaired, received antianxiety medications, and had diagnoses that included dementia. Physician's orders for Resident 11 , dated August 30, 2025, included an order for the resident to receive 0.5 mg of Rexulti (an antipsychotic (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
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on facility policies, observations, and staff interviews, it was determined that the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Findings include: Observations of the walk in cooler on December 1, 2025, at 9:50 a.m. and December 3, 2025 at 1:43 p.m. respectively, revealed a shelving unit with an opened box of eggs and a box containing cartons of liquid eggs being stored on the bottom shelf, which was approximately 1.0 to 1.5 inches off the ground. On the floor beneath the shelving unit was debris including individual butter containers and brown onion skins. Interview with the Dietary Director on December 3, 2025, at 1:43 p.m. indicated that food should be stored at least six inches off the ground and confirmed that the floor underneath the shelf should be free of debris and food items that had fallen. The shelves were recently put in by maintenance. Observations of the facility's dishwasher on December 3, 2025, at 1:24 p.m. revealed that it was a high temperature dishwasher that was converted to a low temp dishwasher with chemical sanitization. There were two dietary staff in the dish room washing dishes at that time and multiple attempts were made to test the sanitization, but the testing strips remained white with no indication of sanitizer in the reading. Interview with the Dietary Manager on December 3, 2025, and again on December 4, 2025, at 12:58 at the time of observation, confirmed that the chemicals were just changed out recently and the machine was serviced on December 3, 2025. There were two companies coming in on December 5, 2025 to check the machine. The sanitizer does not work consistently and the facility has been washing the dishes by hand utilizing the three bin sink. 28 Pa. Code 211.6(f) Dietary Services. 28 Pa. Code 207.4 Ice Containers and Storage.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations and staff interviews, it was determined that the facility failed to provide a clean and homelike environment in residents' dining and activity areas (100 hall), and for two residents who had holes in fitted sheets (Resident 18, 64). Findings include: Observations of the 100 hall dining room on December 1, 2025, at 12:11 p.m. revealed that there were three people eating in the room. There was a small vase of flowers sitting on the windowsill and approximately 30 dead insects that were light brown and dried out also on the windowsill. Observations of the 100 hall dining/activity room on December 3, 2023, at 3:32 p.m. revealed dead insects on the windowsill. Interview with Nurse Aide 1 on December 3, 2025, at 3:32 p.m. confirmed that there were dead insects on the windowsills and that they should have been cleaned up. Interview with the Director of Housekeeping on December 4, 2025, at 10:42 a.m. confirmed that there should not have been any dead insects in the areas mentioned. Observations of Resident 18's bed on December 4, 2025, at 10:45 a.m. revealed that there was a hole approximately 5 millimeters (mm) in size by the head of her fitted sheet. The sheets were very thin and see-through. Observations of Resident 64's bed on December 4, 2025, at 11:02 a.m. revealed that there was a hole approximately 3 mm in size in the bottom of his fitted sheet, and his sheets were very thin and see-through. Interview with the Director of Laundry on December 5, 2025, at 10:49 a.m. revealed that they were able to use sheets with holes as long as the hole was no bigger than the eraser tip of a pencil. Interview with the Director of Nursing on December 5, 2025, at 10:56 a.m. confirmed that the sheets with holes should have been thrown out and not used. 28 Pa. Code 201.29(j) Resident rights.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on a review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents medication regime was free from unnecessary psychotropic medication (drugs that affect a person's mental state, emotions, and behavior) for one of 35 residents reviewed (Resident 4). Findings include: The facility's policy for the use of psychotropic medications, dated March 13, 2025, indicated that psychotropic medications used on an as needed (PRN) basis must have a diagnosed specific condition and indication for the PRN use documented in the resident's medical record and was subject to the limitations as noted: PRN orders for psychotropic medications, excluding antipsychotics, shall be limited to no more than 14 days, unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond the 14 days. The medical record should include documentation from the physician or prescriber for the rationale for the extended time period and indicate a specific duration. An admission Minimum Data Set (MDS) assessment (a federally mandated assessment of the resident's abilities and care needs) for Resident 4, dated September 13, 2025, indicated that the resident was cognitively impaired, received antidepressant and antianxiety medications (psychotropic medications), and had diagnoses that included dementia, depression, and anxiety. Physician's orders for Resident 4, dated October 2, 2025, included an order for the resident to receive 0.5 milligrams (mg) of Xanax (a psychotropic medication used to treat anxiety) every twelve hours as needed for anxiety. Review of the Medication Administration Record (MAR) for Resident 4, dated October 2025, revealed that 0.5 mg of Xanax was administered to the resident on October 19 at 5:03 p.m.; October 21 at 3:51 p.m.; October 23 at 11:29 a.m.; and October 26 at 1:23 p.m. There was no duration included in the physician's order and no documented evidence from a physician or prescriber to indicate the rationale to extend the as needed medication beyond 14 days. Interview with the Director of Nursing on December 4, 2025, at 11:01 a.m. confirmed that there was no duration included in the physician's order on October 2, 2025, and no documented evidence from a physician or prescriber to indicate the rationale to extend the as needed Xanax for Resident 4 beyond 14 days. 28 Pa. Code 211.12(d)(5) Nursing Services.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to notify the resident and the resident's representative, in writing regarding the reason for transfer to the hospital, to ensure that a bed-hold notice was provided to the resident's responsible party and that the ombudsman was notified of the transfer to the hospital, for three of 35 residents reviewed (Residents 9, 40, 46). Findings include: A quarterly minimum data set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 9, dated September 10, 2025, indicated that the resident was cognitively intact, required assistance from staff for all daily care needs, and had diagnoses that included heart failure and end stage kidney disease. A nursing note for Resident 9, dated February 2, 2025, at 11:48 a.m. revealed that the resident had increased weakness and was slow to respond at dialysis, and the resident was being sent to the emergency room. A nursing note dated July 4, 2025, at 10:06 a.m. revealed that the resident was bleeding profusely at the dialysis site and was being sent to the emergency room. A nursing note dated October 8, 2025, at 10:28 a.m. revealed that the resident's fistula site was unable to be accessed during dialysis and the resident was being sent to the emergency room. A nursing note dated November 5, 2025, at 5:43 p.m. revealed that the resident's surgical site was bleeding profusely and she was being sent to the emergency room. A nursing note dated November 24, 2025, at 3:30 a.m. revealed that the resident was having redness around her port site and was not feeling herself and was being sent to the emergency room. There was no documented evidence that written notification of transfer to the hospital was provided to Resident 9 or the resident's representative, no documented evidence that a bed-hold notice was provided to the resident's responsible party, and no documented evidence that the ombudsman was notified of her transfer to the hospital on the above dates and times as required. Interview with the Director of Nursing on December 4, 2025, at 11:18 a.m. confirmed there was no written notification of hospital transfer provided to the resident or their representative, that a bed-hold notice was not provided to their responsible party, and that the ombudsman was not notified of the transfer to the hospital on the above dates and times as required. An annual MDS assessment for Resident 40, dated September 15, 2025, indicated that the resident was cognitively impaired, required substantial assistance from staff for all daily care needs, and had diagnoses that included high blood pressure, high cholesterol, and dementia. A nursing note for Resident 40, dated June 9, 2025, at 10:53 a.m., revealed that the resident was having a large amount of bleeding from his urinary catheter, and hernias and tenderness in his abdomen, and was sent to the emergency room. There was no documented evidence that written notification of transfer to the hospital was provided to the resident's representative, no documented evidence that a bed-hold notice was provided to the resident's responsible party, and no documented evidence that the ombudsman was notified of her transfer to the hospital on the above date and time as required. A quarterly MDS assessment for Resident 46, dated October 20, 2025, revealed that the resident was cognitively impaired and required maximum assistance from staff for daily care needs. A nursing note for Resident 46, dated July 18, 2025, at 6:25 p.m., revealed that the resident was found on the floor and was very disoriented, and was sent to the emergency room for evaluation. There was no documented evidence that written notification of transfer to the hospital was provided to the resident's representative, no documented evidence that a bed-hold notice was provided to the resident's responsible party, and no documented evidence that the ombudsman was notified of her transfer to the hospital on the above date and time as required. Interview with the Director of Nursing on December 4, at 2:54 p.m. confirmed that for Residents 40 and 46 there was no written notification of hospital transfers provided to the resident's representative or ombudsman, and that a bed hold notice was not provided. 28 Pa. Code 201.29(j) Resident Rights.		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that comprehensive significant change Minimum Data Set assessments were completed in the required time frame for two of 35 residents reviewed (Residents 14 and 102). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2025, indicated that the Assessment Reference Date (ARD) was to be no later than the 14th calendar day after determination that a significant change in the resident's status occurred (determination date + 14 calendar days) and the significant change comprehensive MDS assessment was to be completed no later than the 14th calendar day after determination that significant a change in the resident's status occurred (determination date + 14 calendar days). Review of the clinical record for Resident 14 revealed that a significant change in condition was identified on September 25, 2025 and the resident was admitted to hospice services with a diagnosis of Alzheimer's. A significant change MDS assessment for Resident 14, dated October 1, 2025, revealed that the MDS was documented in section Z0500B as being completed on October 13, 2025, which was five days late. Interview with the Registered Nurse Assessment Coordinator (RNAC - a registered nurse who is responsible for the completion of MDS assessments) on December 4, 2025, at 2:59 p.m. confirmed that the significant change comprehensive MDS assessment for Resident 14 should have been completed by October 8, 2025, and it was not. Review of the clinical record for Resident 102 revealed that a significant change in condition was identified on November 18, 2025 and the resident was admitted to hospice services with a diagnosis of vascular dementia. A significant change MDS for Resident 102, dated December 1, 2025, revealed that the MDS was not signed in section Z0500B as completed. Interview with the Registered Nurse Assessment Coordinator on December 4, 2025, at 2:39 p.m. confirmed that the significant change MDS assessment for Resident 102 should have been completed by December 1, 2025, and was still in progress. 28 Pa. Code 211.5(f) Clinical Records.		

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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. Based on review of clinical records and staff interviews, it was determined that the facility failed to follow physician's orders to notify the physician of changes in weight for a resident with edema (fluid retention in body tissues) for one of 35 resident's reviewed (Resident 34), and failed to ensure that medications were provided as ordered by the physician for one of 35 residents reviewed (Resident 62). Findings include: An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 34, dated September 26, 2025, revealed that the resident was cognitively impaired, required assistance for care needs, received a diuretic (water pill) medication, and had a diagnosis that included heart failure (the heart can't pump blood as well as it should causing weight gain due to fluid to build up in the lungs and lower legs). Physician's orders for Resident 34, dated November 12, 2025, included an order for the staff to weigh the resident daily for weight gain/increase in edema and to notify the physician for a weight gain of greater than three pounds. A review of Resident 34's clinical record and Treatment Administration Record (TAR) for November 2025, revealed that the resident's weight on November 19 was 195.3 pounds and the resident's weight on November 20 was 203.2 pounds, indicating a 7.9 pound weight gain. The resident's weight on November 23 was 193.7 pounds and the resident's weight on November 24 was 203.2 pounds, indicating a 9.5 pound weight gain. The resident's weight on November 27 was 203.6 pounds and the resident's weight on November 28 was 208.8 pounds, indicating a 5.2 pound weight gain. There was no documented evidence that the physician was notified of the resident's weight gain of greater than three pounds on November 20, November 24 and November 28. An interview with the Director of Nursing on December 3, 2025, at 11:18 a.m. confirmed that there was no documented evidence that the physician was notified of Resident 34's weight gain of greater than three pounds on November 20, November 24 and November 28. An annual MDS assessment for Resident 62, dated September 18, 2025, revealed that the resident was cognitively intact, required assistance for care needs, and had a diagnosis that included high blood pressure. Physician's orders for Resident 62, dated October 31, 2025, included an order for the resident to receive 12.5 milligrams (mg) of metoprolol daily and to hold the medication if the pulse was less than 55. A review of Resident 62's Medication Administration Record (MAR) for November 2025, revealed that the resident's pulse was 53 on November 26, 2025, and 42 on November 28, 2025, and metoprolol was administered. An interview with the Director of Nursing on December 4, 2025, at 1:18 p.m. confirmed that the metoprolol was administered on the above dates and times and should not have been. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on review of clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that an updated order was obtained for the correct foley size available for urinary catheterization (a flexible tube inserted into the bladder to drain urine) was completed as ordered for one of 31 residents reviewed (Resident 40). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 40 dated September 15, 2025, revealed that the resident was cognitively impaired, required assistance for care needs, and had a diagnosis of neurogenic bladder (a bladder dysfunction causing urinary incontinence or retention). Physician's orders for Resident 40, dated April 30, 2024, included an order for the resident to use an 18 french (size) foley catheter with a 30cc balloon, and may use a 5-10cc balloon if a 30cc balloon was not available. A nursing note for Resident 40, dated October 30, 2025, at 2:03 a.m. revealed that the resident's catheter was not able to be flushed and a 16 french 30cc foley catheter was inserted. Interview with Licensed Practical Nurse 2 on December 3, 2025, at 10:48 a.m. revealed that if they run out of the foley catheter, a provider was to be notified, and a new order obtained. Interview with the Director of Nursing on December 4, 2025, at 11:49 a.m. confirmed that the provider should have been notified that the ordered catheter was not available and a new order should have been obtained. 28 Pa. Code 211.12(d)(5) Nursing Services.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to flush an intravenous catheter (a thin tube inserted into a vein to administer medications and/or fluids) per facility policy for one of 35 residents reviewed (Resident 34). Findings include: The facility's policy regarding intravenous catheter flushing, dated March 13, 2025, indicated that catheters were to be flushed at regular intervals to maintain patency, before and after administration of medications. Staff were to use only preservative free 0.9 % sodium chloride for saline flushes (a mixture of water and salt, with a salt concentration of 0.9%). An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 34, dated September 26, 2025, revealed that the resident was cognitively impaired, required assistance for care needs, received an antibiotic and intravenous medications, and had a diagnosis that included Osteomyelitis (an infection of the bone). Physician's orders for Resident 34, dated November 4, 2025, included an order for the resident to receive two grams (gm) of Ceftriaxone (an antibiotic) intravenously daily for five days. A review of Resident 34's Medication Administration Record (MAR), dated November 2025, revealed that staff administered the two gm of Ceftriaxone intravenously daily on November 4 and 5, 2025; however, there was no documented evidence that Resident 34's intravenous line was flushed with saline solution before and after the administration of the Ceftriaxone. Interview with the Director of Nursing on December 3, 2025, at 11:18 a.m. confirmed that there was no documented evidence that Resident 34's intravenous line was flushed with a saline solution before and after the administration of the Ceftriaxone. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395697	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Embassy of Woodland Park		STREET ADDRESS, CITY, STATE, ZIP CODE 18889 Croghan Pike Orbisonia, PA 17243	
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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on clinical record review and staff interview, it was determined that the facility failed to ensure that residents were assessed and received trauma-informed care to eliminate or mitigate triggers for residents with the diagnosis of Post Traumatic Stress Disorder (PTSD) (a mental and behavioral disorder that develops related to a terrifying event) for one of 35 residents reviewed (Resident 8). Findings include: A Quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated November 3, 2025, indicated that the resident was cognitively impaired, was dependent on staff for daily care needs, and had diagnoses that included depression, anxiety, and PTSD. A review of Resident 46's care plan, dated August 13, 2024, indicated that the resident had PTSD, anxiety, and Traumatic Brain Injury. There was no documented evidence the facility identified Resident 8's specific triggers that could re-traumatize the resident or implement measures as to how facility staff could prevent or minimize triggers from occurring. Interview with the Nursing Home Administrator on December 4, 2025, at 2:15 p.m. revealed that she believed Resident 8 did not trigger PTSD and if the doctor thought it was a real diagnosis the resident would have been reassessed for it quarterly. Interview with the Medical Director on December 4, 2025, at 2:12 p.m. revealed that Resident 8 was admitted with the diagnosis of PTSD and that she was told by the family that the resident was diagnosed with it years ago. The medical director further stated that she believes the daughter would know the resident better than anyone. 28 Pa Code 201.24(e)(4) admission Policy. 28 Pa Code 211.12(a)(d)(3)(5) Nursing Services. 28 Pa. Code 211.16(a) Social Services.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395697	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plan of corrections for an annual survey ending October 3, 2024, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility-maintained compliance with cited nursing home regulations. The results of the current survey, ending December 4, 2025, identified repeated deficiencies related to a homelike environment and safe and sanitary food storage. The facility's plan of correction for a deficiency regarding a homelike environment cited during the survey ending October 3, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F584, revealed that the facility's QAPI committee failed to successfully implement their plan regarding a homelike environment. The facility's plan of correction for a deficiency regarding safe and sanitary food storage cited during the survey ending October 3, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F812, revealed that the facility's QAPI committee failed to successfully implement their plan regarding safe and sanitary food storage. Refer to F584, F812. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.		