

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: 395721	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/06/2025
NAME OF PROVIDER OR SUPPLIER Paramount Nursing and Rehab at Fayetteville, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6375 Chambersburg Road Fayetteville, PA 17222	
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 - Immediate jeopardy to resident health or safety 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, select facility document review, policy review, review of diet guidelines, observations, and staff interviews, it was determined that the facility failed to ensure that care and services were provided in accordance with professional standards of practice to meet the needs of each resident for one of nine residents reviewed (Resident 1). This failure resulted in an Immediate Jeopardy situation for Resident 1 as evidenced by a delay in provision of emergency services which resulted in death. Findings include: Review of facility policy, titled Emergency Procedure-Choking, with a last review date of January 23, 2025, revealed the following, in part, Trained staff will assist the resident which is choking by attempting to expel the foreign body from the airway. Conscious Resident-Standing or Sitting: 1. Ask the resident if he or she is choking. Remember, a choking victim cannot speak or breathe and needs your help immediately. 4. Call for help, but stay with the resident. 6. If the resident cannot cough, only then should abdominal thrusts be performed as follows: a. Stand behind resident. b. Wrap your arms around the resident's waist. c. Make a fist with one hand. d. Place the thumb side of your fist against the resident's upper mid-abdomen, below the ribcage and above the navel. e. Grasp your clenched fist with your other hand. f. Press your fist into the resident's upper abdomen with a quick upward thrust. g. Do not squeeze the ribcage. Contain the force of the thrust to your hands. h. Repeat the thrusts until the foreign body is expelled or the resident loses consciousness. Unconscious Resident Lying Down (or When Unable to Reach Around Resident): 1. Ease the resident as gently as possible to the floor. 3. Position the resident on his or her back with the arms at his or her side. 4. Perform abdominal thrusts as follows: a. Facing the resident, kneel down and straddle resident's upper thighs with your body. b. Place the heel of one hand on the resident's upper mid-abdomen, below the ribcage and above the navel with fingers pointed toward the resident's chest. c. Place the other hand directly over the positioned hand. d. Bring your shoulders forward over your hands. e. Use your body weight to press your hands into the resident's upper abdomen with a quick upward thrust. 5. Perform finger sweep maneuver to check for a foreign body as follows: a. Keep the resident's face up. b. Perform the tongue-jaw lift to open the resident's mouth. (Note: Moving the lower jaw moves the tongue off the throat and opens the airway.) c. Perform the finger sweep using your index finger as a hook. (1) Insert your index finger into the resident's mouth alongside of the cheek and across the base of the tongue. (2) Try to remove any foreign objects. (3) Avoid pushing foreign objects deeper into the throat. (4) Turn the resident's head to one side if needed to sweep an object from the mouth. 6. Alternate steps four 4) and five (5) until the object is expelled. Arrange for the resident to be evaluated by a physician immediately after the foreign body airway obstruction has been removed. 7. If unable to clear the foreign body from obstructing the airway, arrange emergency transport of the resident to the nearest acute care medical facility. 8. Proceed with CPR immediately if the resident has no pulse or respirations. Review of Resident 1's clinical record revealed that he was admitted to the facility on [DATE], with diagnoses that included a compression fracture (collapse of a vertebra possibly due to trauma or a weakening of the vertebra) of the second lumbar (lower part of the back) vertebra, altered mental status, and muscle weakness. Review of Resident 1's physician orders revealed the following orders: Regular diet (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Mechanical Soft texture, with thin consistency, Out of bed to gerichair with left arm support (Recline chair at rest and incline during meals), Advanced Directive DNR/Do Not Attempt Resuscitation; Speech Therapy (ST) Eval & Treat 3-5 days/week x 30 days for Swallow Eval, Dysphagia (difficulty swallowing) treatment; and Occupational Therapy (OT) 5-6 days a week x 30 days for Activities of Daily Living. All orders were dated September 10, 2025. Review of Speech Therapy Evaluation and Plan of Treatment dated September 10, 2025, completed by Employee 3 (Speech Language Pathologist) indicated that Resident 1 was referred to ST due to exacerbation of cognitive impairment, decreased safety awareness, decreased oral pharyngeal function, risk for weight loss, risk for aspiration and decreased functional activity. ST to assess and evaluate the least restrictive oral intake, develop & instruct in compensatory strategies and minimize aspiration risk and promote safety awareness. Review of Resident 1's Speech Therapy progress report note dated September 20, 2025, completed by Employee 3, indicated, Interventions provided: Swallow Tx [treatment]: facilitation of finger foods, facilitation of small bites/sips (1/2 to 1/3 tsp[teaspoon]), facilitation of rate control during oral intake of food/liquid presentation and modification of bolus sizes and order/method of food/liquid presentation. Pt and Caregiver Training: Instructed patient and primary caregivers in safe swallow techniques in order to facilitate improved functional abilities with 100% carryover demonstrated by primary caregivers. Review of Resident 1's Occupational Therapy Evaluation and Plan of Treatment dated September 10, 2025, completed by Employee 11 (Occupational Therapist), indicated, Res[ident] noted with decreased safety awareness. Review of Resident 1's Occupational Therapy Progress Report note dated September 20, 2025, completed by Employee 11, indicated Resident 1 was provided education and encouragement to initiate self-feeding and increase intake. In addition, in supervision section, it was noted Completed on-site consultation between therapist and assistant regarding patient's current status and modified POT [plan of treatment]/goals. It was electronically signed by Employee 1 (Certified Occupational Therapy Assistant) and Employee 11. Review of Resident 1's progress notes revealed a note dated October 1, 2025, at 11:30 AM, completed by Employee 13 (Registered Nurse), that stated, At approximately 1130, resident observed choking during meal consumption. Staff encouraged resident to cough and brought resident to his room. Staff immediately initiated Heimlich maneuver and oral suctioning. Staff encouraged resident to cough, but resident was unable to cough productively due to medical conditions. Resident continued to exhibit airway obstruction, with blue facial color and unable to speak effectively. O2 via non rebreather mask placed on resident during Heimlich maneuver attempts. Emergency protocols initiated and 911 called. At 1157, resident observed to lose consciousness with no findings of spontaneous movement. Auscultation of chest revealed no audible heart sounds over a duration of one minute with no palpable carotid or radial pulse detected B/L [bilaterally-both sides]. Skin noted to be pale and warm to touch. Pupils fixed and dilated. MD [Medical Doctor] updated with new order for RN to pronounce death. Further review of Resident 1's progress notes revealed a late entry note dated October 1, 2025, at 12:57 PM, completed by Employee 6 (RN-Assistant Director of Nursing), that stated This nurse was informed of a possible choking incident around 11:40 AM when walking towards DON [Director of Nursing]/ADON [Assistant Director of Nursing] office. This nurse stopped at nurse's station, checked resident's POLST and noted resident was DNR, at this time RN Supervisor (Employee 13) was at desk on the phone w/[with] 911 operator reporting incident. This nurse then entered resident's room to find LPN [Licensed Practical Nurse] (Employee 2) attempting suction at bedside. 2 CNA's [Certified Nurse Aides] (Employees 4 and 5) at bedside, as well as 2 therapy staff [Employee 1 (Certified Occupational Therapy Assistant) and Employee 3]. This nurse made staff aware that he is a DNR with limited interventions and that they could continue Heimlich efforts and suctioning, O2 applied via nonrebreather mask to help with any oxygenation possible. Resident complexion at that time getting dusky, his eyes did follow staff in the room, small bursts of air exchange with notable wheezing while attempting Heimlich. Staff unable to visualize the blockage in resident's mouth, and suctioning only producing small amounts of mucous with tiny crumbs of (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	he had no pulse, attempted via stethoscope to auscultate a heartbeat, no heartbeat for greater than 60 seconds. Time of death declared 11:57 AM. During a staff interview with Employee 6 (RN-Assistant Director of Nursing) on October 3, 2025, at 1:03 PM, it was confirmed that Resident 1's choking incident started around 11:40 AM and that staff did not initiate the actual Heimlich Maneuver until approximately 11:50 AM, a delay of approximately 10 minutes. During a staff interview with Employee 2 on October 3, 2025, at 1:20 PM, Employee 2 said when she entered the dining room, Resident 1 was seated in his high back wheelchair at approximately a 75-80-degree angle. Employee 2 said she immediately raised Resident 1's chair to a full 90 degree angle. When Employee 2 was asked why the Resident was taken back to his room and transferred to bed before any emergency measures were initiated for the choking episode, she stated, He still had some air exchange and we wanted to get him out of the dining room away from the other residents. Employee 2 stated that Resident 1 went to the dining room for all meals and was on the assisted side of the dining room. Employee 2 confirmed that Resident 1 had poor safety awareness because of his cognitive impairment. Employee 2 also said that the typical process for someone on a mechanical soft diet was to have their food cut up into bite size pieces and that she could not speak as to why Employee 1 did not do this on the day Resident 1's choking incident occurred. Resident 1's room was located at the end of the hallway. During a staff interview and observation with Employee 9 (Maintenance Director) on October 3, 2025, at 3:07 PM, it was revealed that the distance from the dining room to Resident 1's room was approximately 138 feet. On October 3, 2025, at 3:12 PM, the Nursing Home Administrator (NHA) was informed that an Immediate Jeopardy situation had been identified and the IJ template was provided. An immediate action plan was requested. The NHA provided the facility's Immediate Action Plan on October 3, 2025, at 7:28 PM. The plan of action included: Choking policy was reviewed and updated to American Heart Association Standards. All nursing staff currently working in the building will be educated by the Assistant Director of Nursing on the revised choking policy. All other nursing staff will be educated by the Registered Nurse Supervisor prior to the start of their shift. This will include all full-time, part-time, and prn [as needed] nursing staff. The Assistant Director of Nursing will educate all nursing staff currently working on the signs to look for when someone is choking. This will include all full-time, part-time, and prn [as needed] nursing staff. The Rehab Manager audited all residents on current caseload immediately to ensure current Speech Therapy diet recommendations were being followed. The Rehab Manager will audit all residents who have had current Speech Therapy diet recommendations to ensure their current diet order reflects Speech Therapy recommendations. On October 4, 2025, meal service observations between 7:45 and 8:52 AM, revealed no concerns. Interviews, review of revised policy, review of education, and review of audits conducted on October 4, 2025, between 8:35 AM and 11:25 AM, revealed the facility had completed all immediate actions as stated in their plan. Interviews were conducted with 2 Registered Nurses, 2 Licensed Practical Nurses, and 4 Nurse Aides who were all able to state signs of choking and the immediate actions to take should a choking incident occur. They were all also able to indicate how Speech Language Pathologist diet recommendations would be communicated to them. Interviews were also conducted with a Speech Language Pathologist who was able to state the process to be followed to ensure that recommendations are communicated to the dietary department, and with a Certified Occupational Therapy Assistant who verbalized that a Speech Therapist's diet recommendations would be located on a resident's meal tray ticket. Interviews with two Dietary Aides revealed that they were both able to state the measures they are to take in preparing a resident's meal tray for delivery. An interview with the Dietary Manager revealed the process he had developed and implemented with the dietary staff to ensure a resident receives the appropriate diet and that Speech Language Pathologist recommendations are followed. On October 4, 2025, at 11:35 AM, the Immediate Jeopardy was lifted. During a final staff interview with the NHA on October 6, 2025, at 1:52 PM, she confirmed that she would have expected staff to have begun emergency measures for Resident 1's choking event immediately instead of taking the time to take him back to his room, transferring him back to bed, and (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	waiting for further direction to start the Heimlich Maneuver. The facility failed to provide timely emergency services, including the Heimlich maneuver, to Resident 1 when he was choking. This failure resulted in an immediate jeopardy situation. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on clinical record review, select facility document review, review of diet guidelines, review of select resident meal tray tickets, and staff interviews, it was determined that the facility failed to ensure that each resident receives adequate supervision and assistance to prevent accidents based on individual needs for one resident (Resident 1), which resulted in Resident 1 choking. This failure placed nine residents that had similar diet needs at a high risk for death and resulted in an Immediate Jeopardy situation (Resident 6, 7, 8, 9, 10, 11, 12, 13 and 14). Findings include: Review of facility document, titled Mechanically Altered Diets, last reviewed January 23, 2025, read, in part, Dysphagia Diet Level 2: Level 2 can tolerate (most of the time) this texture as it should be the easiest to maneuver and safe to swallow. Mechanically altered food should be very small in size, soft, and with extra moisture added. Review of Resident 1's clinical record revealed diagnoses that included unspecified protein-calorie malnutrition (an imbalance between the nutrients the body needs to function and the nutrients it gets), dehydration (the loss of water and salts essential for normal body function), and generalized muscle weakness. Review of Resident 1's physician's orders revealed he had an order for Regular diet, Mechanical Soft texture, Thin consistency, with a start date of September 10, 2025. Review of select facility diet guidelines revealed residents who were ordered mechanical soft diet texture were to be served a beef enchilada as their entree for lunch on October 1, 2025. Review of Resident 1's clinical record revealed a document titled Speech Therapy Evaluation & Plan of Treatment signed by Employee 3 on September 10, 2025, read, in part, Reason for Referral: Patient referred to speech therapy (ST) due to exacerbation of cognitive impairment, decreased safety awareness, decreased oral/pharyngeal function, risk for weight loss, risk of aspiration (when something swallowed enters the airway or lungs), and decreased functional activity tolerance indicating the need for ST to assess/evaluate least restrictive oral intake, develop compensatory strategies, promote safety awareness/insight and increase verbal problem solving. Review of Resident 1's Speech Therapy progress report note dated September 20, 2025, completed by Employee 3 (Speech Language Pathologist) indicated Interventions provided: Swallow Tx [treatment]: facilitation of finger foods, facilitation of small bites/sips (1/2 to 1/3 tsp), facilitation of rate control during oral intake of food/liquid presentation and modification of bolus sizes and order/method of food/liquid presentation. Pt and Caregiver Training: Instructed patient and primary caregivers in safe swallow techniques in order to facilitate improved functional abilities with 100% carryover demonstrated by primary caregivers. Review of document, titled Speech Therapy Discharge Summary, for Resident 1 and signed by Employee 3 on October 2, 2025, read, in part, Comments: Mechanical soft with ground meats, food cut into bite size pieces. facilitation of small bites/sips (1/2 to 1/3 tsp). Review of Resident 1's meal tray ticket from October 1, 2025, failed to reveal notation that his food should be cut into bite size pieces. Review of facility provided information dated October 1, 2025, revealed that Employee 1 handed Resident 1 a half of an enchilada, measuring approximately 2.5 inches (not bite size). The Resident took one bite and, despite encouraging small bites, he proceeded to put the rest of the enchilada in his mouth. Employee 1 noticed the Resident having a blank stare and he started exhibiting labored breathing. Review of the witness statement written by Employee 1 (Occupational Therapist) read, in part, on October 1, 2025, At approximately 11:40 AM, I handed resident half of a soft beef enchilada approximately 2.5 inches in size. Resident quickly pushed half of the enchilada in his mouth. I provided visual and verbal cues to instruct resident to slow down numerous times. Resident continued to push the remaining enchilada he was holding into his mouth. I noticed resident having a blank stare and starting to exhibit labored breathing while still able to speak. I instructed resident to keep coughing. Resident stated, 'I can't' I then immediately alerted Employee 2 (Licensed Practical Nurse) and Employee 3 (Speech Language Pathologist) for further assistance. Review of witness statement written by Employee 2 read, in part, I was called to the (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	dining room for resident ?choking.' I noted he was awake and breathing with long wheezing respirations. No cyanosis (skin, lips or nails turn blue due to a lack of oxygen in your blood) noted at that time. I raised the back of the wheelchair to a full 90 degree angle with resident continuing to have air exchange. Coughed at one time and moderate amount of mucous was expectorated. Staff present encouraged him to continue to cough to which he replied in a whisper 'I can't.' During an interview with Employee 7 (Therapy Director) on October 3, 2025, at 2:56 PM, she revealed Employee 1 was working with Resident 1 to trial finger foods and self-feeding tasks, but she could not answer as to why she provided food larger than his recommended diet consistently of bite size pieces. Interview with Employee 3 on October 4, 2025, at 11:10 AM, she indicated that the Resident was on the assisted side of the dining room so that staff could assist him with eating. She indicated that assistance would include staff cutting up food, verbally cueing him to feed himself small bites, allow him time to take rest breaks as needed, and assist with feeding if unable to complete independently or with cueing. She said that if she had specific recommendations for a resident that they would be put on the resident's tray ticket, but said that staff should always be cutting up a resident's food to bite size pieces on the assisted side of the dining room. She said she had not specifically spoken to Employee 1 regarding Resident 1's diet or precautions. She said that the other Speech Language Pathologist may have, but she would not know for sure what was discussed. She said in her speculation, Employee 1 should have given the Resident a fourth of the enchilada at a time or push some of the cheese off the enchilada. Review of Resident 6 and 9's meal tray tickets from October 1, 2025, revealed direction for cut up meats. Review of Resident 8, 11, 7 and 12's meal tray tickets from October 1, 2025, revealed direction for cut up food. Review of Resident 10's meal tray ticket from October 1, 2025, revealed direction for cut food into bite size pieces. Review of Resident 13 and 14's meal tray tickets from October 1, 2025, revealed direction for cut food into small pieces. Interview with the Nursing Home Administrator (NHA) on October 6, 2025, at 2:09 PM, revealed she would expect speech therapy recommendations to be communicated properly and noted on meal tray tickets; and she would expect speech therapy recommendations to be followed. The NHA was notified of the IJ situation on October 3, 2025, at 3:12 PM, for the choking incident that occurred on October 1, 2015 and was provided the IJ template. An Immediate Action Plan was requested. The Immediate Action Plan was provided by the NHA on October 3, 2025, and accepted at 7:28 PM. The approved plan included: Choking policy was reviewed and updated to American Heart Association Standards. All nursing staff currently working in the building will be educated by Employee 6 (Assistant DON) on the revised choking policy. All other nursing staff will be educated by the Registered Nurse (RN) Supervisor prior to the start of their shift. This will include all full time, part-time and nursing staff. Employee 6 will educate all nursing staff currently working on the signs to look for when someone is choking. All other nursing staff will be educated by the RN Supervisor prior to the start of their shift. This will include all full time, part-time and nursing staff. Employee 7 audited all residents on current caseload immediately to ensure current speech therapy diet recommendations were being followed. Employee 7 will audit all residents who have had current speech therapy diet recommendations to ensure their current diet order reflects speech therapy recommendations. Employee 7 will educate speech therapists on new procedure to write recommendations on speech therapy recommendation form and physician orders. Employee 7 will educate Employee 1 on following dietary orders on her next scheduled day to work October 3, 2025. Employee 12 (Dietary Manager) will educate dietary staff currently working on diet and diet textures. All other dietary staff members will be educated by Employee 12 prior to the start of their shift. This will include all full time, part-time, and as needed staff. All nursing staff currently working in the building will be educated by Employee 6 on diets and diet textures and to read and follow meal tickets. RN Supervisor will educate all nursing staff currently working on diets and diet textures and to read and follow meal ticket directions. Employee 12 (Dietary Manager) audited tonight's evening meal service tray line to ensure meal tickets matched diet order and visually observed meal service was accurate. All meals will be audited during tray line (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to ensure meal ticket matches diet order and visually observe meal served is accurate. On October 4, 2025, between 7:45 AM and 8:52 AM, breakfast meal service was observed to ensure all residents received the appropriate texture diet per their physician order. The audit of dinner service on October 3, 2025, as well as the audit of breakfast service on October 4, 2025, were reviewed without concern. Staff interviews revealed the facility had re-educated staff on mechanically altered diets and the choking policy. Interviews were conducted with two registered nurses, two licensed practical nurses, four nursing assistants, two dietary employees, the dietary manager, speech therapist and occupational therapist; all were able to verbalize their role in providing appropriate diet textures. On October 4, 2025, at 11:35 AM, the Immediate Jeopardy was lifted when the action plan implementation was verified. The facility failed to communicate and follow speech therapy recommendations for bite size pieces for Resident 1, which resulted in Resident 1 choking. This failure placed nine residents that had similar diet needs at a high risk for choking and possible death and resulted in an Immediate Jeopardy situation (Resident 6, 7, 8, 9, 10, 11, 12, 13 and 14).28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1)(3) Management.28 Pa. Code 211.12(c)(d)(1)(2)(3)(5) Nursing services.		