

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395752	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/21/2024
NAME OF PROVIDER OR SUPPLIER  Moravian Hall Square Health and Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 175 West North Street Nazareth, PA 18064	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45125</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to develop a comprehensive care plan to meet each resident's needs identified in the comprehensive assessment for one of 16 sampled residents. (Resident 32)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 32 was admitted to the facility on [DATE], and had diagnoses that included polyosteoarthritis and muscle weakness. The Minimum Data Set (MDS) Care Area Assessment (CAA) summary dated February 18, 2024, noted that the resident's urinary incontinence was to be addressed in the care plan. There was no documented evidence that interventions to address Resident 32's urinary incontinence were included in the current care plan.</p> <p>In an interview on March 21, 2024, at 9:21 a.m., the Corporate Compliance Officer confirmed there was no documented evidence that the identified care area (urinary incontinence) was addressed in Resident 32's current care plan.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</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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