

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION This was a risk-based inspection, not a standard inspection. A risk-based inspection is a shorter visit by a smaller inspection team and is only done for high-performing facilities.	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395763	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Fellowship Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 3000 Fellowship Drive Whitehall, PA 18052	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on facility policy review, clinical record review, observation, and staff interview, it was determined that the facility failed to follow policies and procedures to prevent the spread of infection for one of 26 sampled residents. (Resident 6) Findings include: Review of the facility policy titled, Emerging and Other Infectious Diseases, last reviewed June 2026, revealed that a gown and gloves were to be worn with any high contact resident care activity which included wound care. Clinical record review revealed that Resident 6 had diagnoses that include type two diabetes mellitus without complications (a chronic condition characterized by one's body being resistant to insulin, or not producing enough of it, causing high blood sugar), and pressure ulcer of left ankle, stage four (a severe, full-thickness wound extending through the skin into underlying muscle, tendon, or bone). Review of Resident 6's care plan revealed that the resident was to receive a protective dressing to the left lateral ankle. During an observation of wound care to Resident 6's left ankle pressure ulcer, on July 8, 2026, at 10:45 a.m., the Registered Nurse (RN 1) performed a dressing change to the resident's wound. RN 1 did not wear a gown during the dressing change. On July 8, 2026, at 1:00 p.m., the Assistant Director of Nursing confirmed that RN 1 did not use appropriate personal protective equipment (PPE) during Resident 6's dressing change. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 395763	If continuation sheet Page 1 of 2

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review and staff interview, it was determined that the facility failed to provide copies of the written discharge notices to a representative of the Office of the Long-Term Care Ombudsman for three out of three residents who were discharged from the facility. (Residents 108, 120, and 122) Findings include: Clinical record review revealed that Resident 108 was discharged from the facility on May 16, 2026. There was no documented evidence that the facility sent copies of the written discharge notice to a representative of the Office of the State Long-Term Care Ombudsman. Clinical record review revealed that Resident 120 was discharged from the facility on May 24, 2026. There was no documented evidence that the facility sent copies of the written discharge notice to a representative of the Office of the State Long-Term Care Ombudsman. Clinical record review revealed that Resident 122 was discharged from the facility on May 19, 2026. There was no documented evidence that the facility sent copies of the written discharge notice to a representative of the Office of the State Long-Term Care Ombudsman. In an interview on July 8, 2026, at 2:27 p.m., the Administrator confirmed that the written copies of the discharge notices were not sent to the Office of the State Long-Term Care Ombudsman. 28 Pa. Code 201.14(a) Responsibility of licensee.		