

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Complete Care at Harston Hall LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 350 Haws Lane Flourtown, PA 19031	

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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>Based on review of clinical records, observations, review of facility policy and interviews with residents, it was determined that the facility failed to ensure a resident was treated with dignity and respect during wound care for one of 12 residents reviewed (Resident R1). Findings include: Review of Facility policy titled Clean dressing change, date implemented September 1, 2024, under Policy explanation and Compliance Guidelines, step 1 states Explain the procedure to the resident and screen for privacy. Review of Resident R1's clinical record revealed resident was admitted to facility on August 13, 2025, with the diagnosis of Sepsis (infection in the blood stream), Paraplegia (paralysis on the lower half of the body), and Pressure Ulcer of Left Buttocks. Review of Resident R1's Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) dated September 11, 2025, revealed that the resident has a BIMS (Brief interview for Mental Status) score of 15 indicating that resident cognitively intact. Observation of Resident R1's wound care with Employee E4, Licensed Practical Nurse on September 17, 2025, at 12:30pm revealed resident left with exposed buttocks after perineal care, for approximately 2 minutes, while staff prepared for dressing change. Observed multiple unnamed staff members entering and exiting room without introduction or providing the resident with privacy. Interview with Resident R1 on September 17, 2025 at 12:45pm, revealed that this experience happens often when care is being provided and it makes him feel very uncomfortable. People come and go while I am getting care, I don't know who they are, they do not introduce themselves, sometimes it someone dropping off a tray, other times it is housekeeping. It's uncomfortable when I am exposed and have no privacy and it doesn't seem like anyone cares. 28 Pa. Code: 201.18(b)(2) Management. 28 Pa. Code: 201.29(j) Resident's rights.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policies, facility documentation, review of clinical records and interviews with residents and staff, it was determined that the facility failed to conduct a thorough investigation related to potential resident abuse and/or neglect related to a grievance for one of 12 residents reviewed. (Resident R2) Findings include: Review of facility policy titled Abuse, Neglect and Exploitation, implemented on September 1, 2025, revealed It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Further review revealed definition of Mental Abuse includes, but is not limited to, humiliation, harassment, threat of punishment or deprivation. Mental abuse also includes abuse that is facilitated or caused by nursing home staff taking or using photographs or recording in any manner that would demean or humiliate a resident(s). Mistreatment- means inappropriate treatment or exploitation of a resident Verbal abuse- means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Further review revealed, under section V. Investigation of alleged Abuse, Neglect and Exploitation, An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigation include: Identifying staff responsible for the investigation; Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence); Investigating different types of alleged violations; Identifying and Interviewing all involved persons, including the alleged victims, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent and cause; and providing complete and thorough documentation of the investigation. Review of Resident R2's clinical record revealed that resident was admitted to the facility on [DATE], with the diagnosis of End Stage Renal Disease. Review of Resident R2's Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) dated August 20, 2025, revealed that the resident has a BIMS (Brief interview for Mental Status) score of 15 indicating that resident was cognitively intact. Review of facility grievance revealed concern form dated August 26, 2025 with letter attached signed by Resident R2's family. Letter revealed At approximately 8:50pm, I received a call from my mother, [Resident R2]. She was very upset. She told me that an aide/orderly had treated her poorly and she was very hurt. She asked the aide to help her get in the chair so that she could use the bathroom. The aide told her no and that she had to get in the bed. She asked again and was told the same thing. Shortly after being put in the bed, my mom had an accident. When the aide returned and found that she had soiled herself, her tone was demeaning and she said, This is just a mess! (In a mean tone). My mom also said that she was very forceful while changing her. This is unacceptable. My Mom said that she felt hurt and embarrassed. She should not be made to feel this way and my family would like to know what the consequence will be for this behavior. We need to know that she is safe and cared for while in this facility, we are officially requesting an apology from this worker and assurance that this will not happen again. Sincerely, The family of [Resident R2] Request for incident investigation on September 17, 2025 at 1:30pm revealed no documented evidence of investigation completed. Further review of grievance form dated August 26, 2025, revealed that Employee E5 Nurse Aide (CNA) was identified. Employee E5 was provided education on customer service and perineal care on August 28, 2025. Interview with Employee E2, Director of Nursing confirmed no documented evidence of investigation completed regarding the concern of abuse and neglect. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.29 (a) Resident rights</p>		