| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395791 | A. Building<br>B. Wing | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Complete Care at Harston Hall LLC | 350 Haws Lane<br>Flourtown, PA 19031 |

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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 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, facility documentation, and staff interviews, it was determined that the facility failed to ensure that one (1) of twenty-two (22) residents reviewed was free from physical restraint. (Resident R57).Findings include: Review of facility policy titled Restrain Free Environment, last revised 3/24/26, states, It is the policy of this facility that each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of physical or chemical restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of such restraints, and further defines Physical Restraint as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily and that restricts freedom of movement or normal access to one's body, including but not limited to applying leg or arm restraints, hand mitts, soft ties, or vests the resident cannot remove; using bed rails to prevent voluntary exit from bed; tightly tucking sheets or fastening clothing to restrict movement; placing a chair or bed close enough to a wall to prevent rising; placing a resident on a concave mattress to prevent independent exit; holding down a resident in response to behavioral symptoms or during care when resistive; placing a resident in an enclosed framed wheeled walker they cannot exit; and using a position change alarm that discourages movement due to fear of triggering the alarm. Review of the clinical record revealed Resident R57 was admitted to the facility on [DATE], with diagnoses of parkinsonism (brain condition that causes slow movements, rigidity and tremors) , dementia (progressive degenerative disease of the brain), difficulty in walking, muscle weakness, adult failure to thrive, and age-related osteoporosis without current pathological fracture (low bone density related to aging, which makes bones weaker and more fragile). Review of the MDS (Minimum Data Set - Assessment of Resident Care Needs) dated December 17, 2025, revealed that the resident had moderate cognitive impairment in decision-making skills. On April 20, 2026, at 11:24 p.m., observation revealed Resident R57 sitting in the hallway across from the nursing station next to the elevators in a Geri chair reclined at 90 degrees, yelling, Move me, move me. The resident had a tray table positioned in front of him, blocking access. Resident R57 was asked to attempt to move the tray table forward and was observed pushing it to allow access; however, he stated, I can't. Observation revealed that the side table wheels were positioned between the Geri chair wheels, effectively locking the resident in the chair and preventing him from exiting independently. A licensed nurse, Employee E9, who was sitting at the nursing station, yelled, Resident R57, come on, you can get out, then approached and removed the wheeled side table from underneath the resident's chair. When the surveyor requested that staff not intervene, Employee E9 stated, He can't get out, and pulled the side table away, confirming that Resident R57 was unable to exit the chair independently. On April 21, 2026, Resident R57 was observed sleeping throughout the day. On April 22, 2026, at approximately 12:18 p.m., Resident R57 was observed sitting in a wheelchair by the nursing station, which provided him the ability to propel himself. An unidentified staff member approached, unlocked the wheelchair brakes, and transported Resident R57 to the dining room. Resident R57 was then<br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | observed sitting at the dining table preparing to eat lunch. The surveyor requested observation of whether Resident R57 was able to propel himself away from the dining table independently; however, Resident R57 was unable to move himself away from the table. At that time, the Rehabilitation Director, Employee E10, entered the dining room and reported that Resident R57 was able to self-propel approximately 30 feet; however, if the wheelchair brakes were locked, Resident R57 was unable to unlock them independently. Employee E10 pointed out that the wheelchair brakes were currently locked and confirmed that Resident R57 was unable to unlock the brakes or move himself away from the dining table without staff assistance. Resident R57 required staff assistance to unlock the wheelchair brakes to self-propel. On April 23, 2026, at approximately 11:00 a.m., an additional observation was conducted with the Director of Nursing, Employee E2, and the Administrator, Employee E1. It was confirmed that Resident R57 had no need for physical restraints, and there was no physical restraint evaluation or physician order for a physical restraint. It was further confirmed that Resident R57 requires staff assistance to unlock the wheelchair brakes in order to self-propel. It was additionally discussed that on April 20, 2026, Resident R57 was observed in a situation involving a physical restraint, as he was unable to exit the Geri chair. The side table wheels were positioned between the Geri chair wheels, effectively locking the resident in the chair and preventing independent exit. A tray table was also positioned in front of the resident, blocking access. 28 Pa. Code 201.12(d)(1) Nursing services. 28 Pa. Code 211.8(e)(f) Use of restraints. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility failed to ensure implementation of a fall prevention intervention for 1 of 22 resident reviewed. (Resident R52)Findings include:Review of Resident R52's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including Essential (Primary) Hypertension (high blood pressure), Anxiety Disorder (persistent nervous feelings), and history of falling (past falls reported). On April 21, 2026, at 8:45 am, on the 3rd floor, during observation of a medication pass with Licensed Nurse Employee E16, the surveyor observed a sign posted on Resident R52's wall that read, Floor mats need to be placed at all times. Further observation revealed no floor mats in place on the floor next to the resident's bed. One floor mat was found standing against the wall, under the posted sign; no mats were positioned on either side of the bed.On April 21, 2026, at 8:47 am, Licensed Nurse, Employee E16 confirmed that the floor mats were not in place at the time of observation. The nurse retrieved the mat from the wall and placed one floor mat on the left side of the bed. Further review of Resident R52's care plan on April 21, 2026, at 10:43 AM revealed an intervention for bilateral floor mats at all times, initiated on 12/11/2024. 28 PA. Code 211.12(d)(1)(5) Nursing services |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>Based on review of facility policy, clinical records, observations and staff interviews, it was determined that the facility failed to provide appropriate respiratory care and maintain oxygen equipment for one of two sampled residents (Residents R58)Findings include: A review of the facility policy titled Oxygen Policy, last revised on January 7, 2025, revealed, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. A review of Resident R58's clinical record revealed an admission date of October 11, 2019, with diagnoses including chronic obstructive pulmonary disease (COPD- a progressive lung disease that causes airflow limitation). A physician's order dated June 3, 2025, revealed, Oxygen at 2 liters via nasal cannula continuously during day and night shifts. Review of the resident's comprehensive care plan, last revised on April 14, 2025, revealed, The resident has COPD, with a goal that the resident will be free of signs and symptoms of respiratory infections through the review date, and an intervention of Oxygen at 2 liters via nasal cannula continuously. On April 20, 2026, at 1:44 p.m., an observation was conducted with Licensed Nurse, Employee E11, who confirmed that Resident R58's oxygen was set at 3 liters, which was inconsistent with the physician's order. On April 21, 2026, at 2:04 p.m., an observation was conducted with the Director of Nursing, Employee E2, and Regional Nurse, Employee E3, who confirmed that Resident R58's oxygen was set at 1 liter, which was also inconsistent with the physician's order of 2 liters continuously. 28 Pa Code 211.12(d)(1)(5) Nursing services |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy, and interview with staff, it was determined the facility failed to ensure pain medication was administered in accordance with the physician's order for two of two residents reviewed for pain management. (Resident R 7 and Resident R16) Findings include: Review of Resident R16's clinical record revealed Resident R16 was admitted to the facility on [DATE] with a diagnosis of congestive heart failure (condition where the heart can't pump blood as well as it should), type 2 diabetes mellitus ((insufficient production of insulin, causing high blood sugar), pain in left shoulder. Review of Resident R16's clinical record revealed physician's order, dated November 10, 2025, for Tramadol 50 milligrams to be given every 6 hours as needed for severe pain, pain scale 7-10. Review of Resident R16's April 2026 Medication Administration Record (MAR) revealed that the as needed pain medication Tramadol 50 mg was administered out of the parameter ordered by the physician as follows:April 1, 2026- Pain level 3April 2, 2026- Pain level 5April 3, 2026- Pain level 3April 5, 2026 Pain level 5April 13, 2026- Pain level 4April 16, 2026- Pain level 5April 22, 2026- Pain level 0 Interview on April 22, 2026, at 12:10 p.m. with Regional Director of Nursing, Employee E3, confirmed Resident R16's pain medication was not administered in accordance with physician's order. Review of facility policy Pain Management, revised on September 1, 2025, revealed the facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Under section Pain Management and Treatment number seven (h) Opioid treatment for acute pain, subacute pain, and chronic pain will be prescribed and dosed in accordance with current professional standards of practice and manufacturer guidelines to optimize their effectiveness and minimize their adverse consequences.During an interview with the Regional Director of Nursing Employee E3 and Assistant Director of Nursing Employee E2 on April 22, 2026, at 10:30 am confirmed Resident R 7 and Resident R 16's pain medication was not administered in accordance with physician orders.Review of Resident R7's clinical record revealed, Resident R7 was admitted to the facility on [DATE] with a diagnosis of displaced intertrochanteric fracture of left femur sequela, traumatic compartment syndrome and contusion of left thigh.Review of Resident R7's Medication Administration Record for April 2026 revealed that the as needed pain medication Oxycodone 5 milligrams every six hours for severe pain (7-10) was administered out of the parameters ordered by the physician as follows:April 17,2026 at 1:54 pm Pain level 7April 18,2026 at 7:41 am Pain level 6 April 20,2026 at 5:01 pm Pain level 6April 21,2026 at 9:50 am Pain level 6 28 Pa. Code 211.10(c) Resident care policies28 Pa. Code 211.12(d)(1) Nursing services |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain dental services for each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility documentation, and interview with resident and staff, it was determined the facility failed to ensure necessary dental services were arranged and followed up for one of six residents reviewed. Findings include: Review of Resident R102's clinical record revealed the resident was admitted to the facility on [DATE] with a diagnosis of dementia (decline in cognitive function that interferes with daily life), type 2 diabetes (insufficient production of insulin, causing high blood sugar), and peripheral vascular disease (condition where blood vessels outside the heart-usually in the legs-become narrowed or blocked, reducing blood flow). Interview on April 20, 2026, at 11:00 a.m. with Resident R102 revealed the resident does not have dentures and had requested dentures several times. Review of R102's dental consult, dated March 17, 2025, revealed the dentist recommended impressions for full upper and lower dentures in 3 weeks. Review of Resident R102's dental consult, dated July 30, 2025, revealed the resident was evaluated and expressed a desire to obtain dentures. The consultation indicated the need for follow-up to address the resident's request for dentures. Review of Resident R102's clinical record revealed no evidence that the facility arranged for or followed up on dental services to obtain dentures following the consult. Interview on April 21, 2026, at 11:15 p.m. with Administrator, Employee E1, confirmed there was no documentation about further dental consults for Resident R102. 28 Pa. Code 211.12(d)(1)(5) Nursing services |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>Based on observation, review of facility policy, and interview with staff, it was determined the facility failed to ensure that there was an adequate emergency food supply available. Findings include: Findings include Review of facility policy on April 20, 2026, at 1:15 p.m. revealed the facility is required to maintain, at all times, a minimum three-day supply of nonperishable and perishable staple food items sufficient to implement its emergency menu. Inventory must be physically present, organized, and readily accessible to ensure continuity of meal service during emergencies. During a tour of the dietary department on April 20, 26 at 9:37am in the company of Food Service Manager, Employee E18, the surveyor requested documentation of the facility's three- day emergency food service plan and corresponding inventory. Review of the three-day emergency menu was provided for review. A physical inventory of available food supplies was then completed and compared against the three-day emergency menu. Interview with Food Service Manager, Employee E18 confirmed there was not enough emergency food supply for three days available at the time of the observation. Employee E18 stated during interview that a food order could be obtained within 24 hours. Observation of the Food Emergency Storage on April 21, 2026, 9:45 am revealed the emergency supply did not have enough emergency food supply for 3 days available at the time of observation. 28 Pa. Code 201.18(b)(3) Management |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, it was determined that the facility failed to maintain proper food temperatures during meal service on one of two nursing units. (3rd Floor)Findings include: Observations conducted on April 22, 2026, at 11:10 AM, of the lunch meal delivery to the 3rd floor nursing unit revealed that the meal tray cart was loaded in the kitchen at 11:34 a.m. At 11:37 AM, the meal cart arrived on the 3rd floor for meal distribution. On April 22, 2026, at 11:45 AM, test tray temperatures were obtained in the presence of the Food Service Director (Employee E14). The following temperatures were recorded:Pork chop: 127 FSpinach: 131 [NAME] juice: 51 [NAME] April 22, 2026, at 11:50 AM, the Food Service Director, Employee E14 confirmed the recorded temperatures and acknowledged that the pork chops and spinach were below the required hot holding temperature of 135 Fahrenheit (F). Employee E14 also confirmed the red juice temperature exceeded the recommended cold holding temperature of 41 F. 28 Pa Code 201.18(b)(3) Management |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>Based on observations and staff interviews, it was determined that the facility failed to maintain the confidentiality of residents' medical information on one of three nursing units reviewed (3rd Floor Medication Cart).Findings include: During an observation on April 22, 2026, at 12:04 p.m. the license nurse, Employee E14 confirmed Medication Cart that was assigned to license nurse, Employee E15 which revealed to be left unattended with the computer screen open with identifiable information any passerby could see resident personal and confidential information. Employee E15 was not in the hallway nor near her medication cart. During an observation on April 22, 2026, at 12:33 p.m., the Rehabilitation Director, Employee E10, confirmed that a medication cart assigned to Licensed Nurse, Employee E15, was left unattended with the computer screen open, displaying identifiable resident information visible to any passerby, exposing personal and confidential medical information. Employee E15 was not present in the hallway or near the medication cart at that time. When Employee E15 returned to the medication cart, she confirmed that Resident R40's information was displayed on the screen while the computer had been left unattended. During the conference meeting, the Director of Nursing, Employee E2, and Regional Nurse, Employee E3, confirmed that nurses are required to lock their computer screens when leaving the medication cart unattended. It was further confirmed that Licensed Nurse, Employee E15, had already reported to the Director of Nursing that the computer was left unattended with Resident R40's medical information displayed on the screen while the nurse was in another resident's room. During an observation on April 22, 2026, at 12:04 p.m. the license nurse, Employee E14 confirmed Medication Cart that was assigned to license nurse, Employee E15 which revealed to be left unattended with the computer screen open with identifiable information any passerby could see resident personal and confidential information. Employee E15 was not in the hallway nor near her medication cart. Employee E14 was inside a resident room administering medication 28 Pa. Code 211.5(b) Medical records |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on a review of facility policy, observations, and staff interviews, it was determined that the facility failed to implement Enhanced Barrier Precautions for one of two residents reviewed who had a midline catheter and an indwelling urinary Foley catheter (Resident R4). Findings include: A review of the facility policy titled Enhanced Barrier Precautions, last revised on February 25, 2025, revealed that Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce the transmission of multidrug-resistant organisms through the targeted use of gowns and gloves during high-contact resident care activities. The policy further revealed that the facility may use EBP for residents who do not have a chronic wound or indwelling medical device but are infected or colonized with a multidrug-resistant organism considered epidemiologically important. In addition, the policy revealed that an order for Enhanced Barrier Precautions is to be obtained for residents with wounds, including chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers, and/or indwelling medical devices, including central lines, urinary catheters, feeding tubes, tracheostomy or ventilator tubes, hemodialysis catheters, PICC lines, and midline catheters, even if the resident is not known to be infected or colonized with a multidrug-resistant organism. A review of Resident R4's clinical record revealed an admission date of September 23, 2019, with diagnoses including sepsis (a life-threatening condition caused by the body's extreme response to an infection). A review of physician orders revealed an order dated April 17, 2026, for a midline catheter for intravenous (IV) fluids, and an order dated January 23, 2026, for Enhanced Barrier Precautions for ESBL colonization, Foley catheter, and wound care during day and night shifts for infection control, with instructions to ensure signage was visible outside the room and personal protective equipment was available. On April 20, 2026, at 1:30 p.m., an observation conducted with Licensed Nurse, Employee E11, revealed a sign posted outside Resident R4's room stating Enhanced Barrier, providing guidance that anyone providing direct care was required to wear a gown and gloves when touching Resident R4. Employee E11 was asked to provide assistance in observing the resident's midline catheter for IV fluids. Employee E11 donned gloves and proceeded to touch the resident's arm while showing the surveyor the midline catheter, including the appropriately dated dressing; however, Employee E11 did not don a gown while providing direct care to Resident R4. On April 21, 2026, at 2:28 p.m., observation confirmed that Resident R4 had a midline catheter and an indwelling Foley catheter, both of which required staff providing direct care or handling the devices to wear a gown and gloves in accordance with the facility's Enhanced Barrier Precautions policy. 28 Pa. Code 211.10 (d) Resident care policies.28 Pa. Code 211.12 (d)(5) Nursing services. |