

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395796	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Montgomeryville Skilled Nursing and Rehabilitati		STREET ADDRESS, CITY, STATE, ZIP CODE 640 Bethlehem Pike Montgomeryville, PA 18936	
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to establish clear advance directives for 5 of 11 sampled residents. (Residents 2, 5, 8, 9, 10) Findings Include: Review of the facility policy entitled, Health Care Decision Making, dated [DATE], revealed that it was the right of all residents to participate in their own health care decision-making, including the right to decide whether they wish to request, accept, refuse, or discontinue treatment, and to formulate or not to formulate an advanced directive. Review of the facility policy entitled, Cardiopulmonary Resuscitation (CPR), last reviewed [DATE], revealed that the center will perform CPR on all patients, except in certain limited circumstances, unless there is a written physician's order, agreed by the patient or health care representative, not to resuscitate, in accordance with state regulation/law. Clinical record review revealed that Resident 2 was admitted to the facility on [DATE], with diagnoses that included dementia, metabolic encephalopathy (a brain malfunction or disease caused by chemical imbalances, systemic illnesses, or organ dysfunction rather than direct physical injury), and delusional disorders. The Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident was cognitively impaired. On [DATE], a physician's order indicated Resident 2 was a DNR (do not resuscitate, patient does not wish to receive any life-saving interventions if their heart stops or they stop breathing). There was no evidence of an advanced directive or Physician Orders for Life-Sustaining Treatment (POLST) on resident 2's medical record to confirm. Clinical record review revealed in the physician's monthly progress notes for May, June and [DATE], that the resident was a full code (full life-sustaining treatment-cardiac pulmonary resuscitation). In an interview on [DATE], at 10:30 a.m., Registered Nurse (RN) 1 and Licensed Practical Nurse (LPN) 1, confirmed that Resident 2 was a full code, the physician had not updated the order in the medical record, but staff had been aware of her full code status. Staff continued to state that they confirm advance directives by reviewing the code status section of the resident profile first, if that is left blank, they review the POLST on the physical chart. If the POLST is incomplete or missing from the chart, staff would perform CPR. Clinical record review revealed that Resident 5 was admitted to the facility on [DATE], with diagnoses that included alcoholic cirrhosis of the liver (permanent, severe scarring of the liver caused by heavy drinking) and dementia. The Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident was cognitively impaired. A review of Resident 5's active physician orders revealed no evidence of an advanced directive or Physician Orders for Life-Sustaining Treatment (POLST). There was no documented evidence that Resident 5 or the resident's responsible party were offered or assisted if needed in formulating an advance directive. Clinical record review revealed that Resident 8 was admitted to the facility on [DATE], with diagnoses that included metabolic encephalopathy, (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Alzheimer's disease, and chronic kidney disease. The MDS assessment dated [DATE], indicated that the resident was cognitively impaired. A review of Resident 8's active physician orders revealed no evidence of an advanced directive or Physician Orders for Life-Sustaining Treatment (POLST). There was no documented evidence that Resident 8 or the resident's responsible party were offered or assisted if needed in formulating an advance directive. Clinical record review revealed that Resident 9 was admitted to the facility on [DATE], with diagnoses that included left lower leg amputation at knee level, heart failure, and diabetes. The MDS assessment dated [DATE], indicated that the resident had no cognitive impairment. A review of Resident 9's active physician orders revealed no evidence of an advanced directive or Physician Orders for Life-Sustaining Treatment (POLST). There was no documented evidence that Resident 9 was offered or assisted if needed in formulating an advance directive. Clinical record review revealed that Resident 10 was admitted to the facility on [DATE], with diagnoses of muscle wasting and atrophy and paranoid schizophrenia. The MDS assessment dated [DATE], indicated that the resident had no cognitive impairment. A review of Resident 10's active physician orders revealed no evidence of an advanced directive or Physician Orders for Life-Sustaining Treatment (POLST). There was no documented evidence that Resident 10 was offered or assisted if needed in formulating an advance directive. In an interview on [DATE], at 3:00 p.m., the Administrator confirmed there were no advanced directives or POLSTs in the residents' records and that Resident 2's physician order should have reflected the resident's wishes. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.10(c) Resident care policies.		