STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395815	A. Building B. Wing	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Martha Center for Rehabilitation & Healthcare	470 Manor Ave Downingtown, PA 19335

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the facility's policy, a clinical records review, observations, and staff interviews, it was determined that the facility failed to comprehensively investigate an injury of unknown origin for one of the two residents reviewed (Resident 1). Findings: A review of the facility's policy titled Abuse Prevention/Reporting, revised on February 25, 2025, revealed that procedures have been developed and implemented to properly screen, report, protect, investigate, and correct issues relating to abuse. Staff are trained to determine types of abuse, stress management tips, and recognition of signs and symptoms of abuse, which may include, but are not limited to, the following: bruises, skin tears, welts, etc., of unknown origin, unexplained injuries. The same policy revealed: The following is a list of methods to be used to conduct the investigation: Review of records; Observe and interview residents, staff members, accused personnel, witnesses, family members, and visitors; Compile written documentation that includes signed witness statements. A review of Resident 1's diagnosis list includes Cerebral Vascular Accident (CVA- An interruption in the flow of blood to cells in the brain), Alzheimer's disease (irreversible, progressive degenerative disease of the brain, resulting in loss of reality contact and functioning ability), Seizure Disorder (neurological conditions characterized by recurring unprovoked seizures) and Osteoporosis (A chronic bone disease that causes bones to become porous, brittle, and highly susceptible to fractures from minor falls or daily activities). A review of Resident 1's quarterly Minimum Data Set (MDS- a standardized assessment tool that measures health status in long-term care residents) dated May 11, 2026, revealed the resident had severe cognitive impairment and was dependent on all ADL's (activities of daily living). A review of Resident 1's nursing progress notes documented by the unit manager, licensed nurse Employee E3 dated June 9, 2026, at 2:24 p.m., revealed Received in report this resident had left hip pain, resident does flinch when I touch left knee (Resident 1) has slight edema (swelling) to left knee it is not red, no discharge, no odor, clean, dry and intact. (Resident 1) had Hemiplegia (paralysis of one side of the body) and Hemiparesis (weakness or partial loss of movement on one entire side of the body), notified MD (physician). The physician ordered ace wrap for the left knee. A review of Resident 1's nursing progress notes dated June 11, 2026, at 9:00 a.m., revealed Resident medicated with Tramadol (A medication used to treat moderate to moderately severe pain) this shift due to facial grimace and moan during transfer and reposition. Misaligned leg noted after informed by companion. A review of Resident 1's nursing progress notes dated June 11, 2026, at 9:10 a.m., revealed: Resident continues to have decreased ROM (range of motion), pain to left LE (lower extremity) call to MD (physician), new order for left hip and knee X-ray stat (immediately). RP (responsible party) is aware. A review of Resident 1's nursing progress notes dated June 11, 2026, at 1:11 p.m., revealed Xray of left knee total knee prosthesis with acute displaced angulated supra condylar fracture abutting the femoral portion of the hardware (is a complex injury where the femur breaks above the condyles, with significant displacement and angulation), Osteoporosis suprapatellar effusion and diffuse STS (refers to fluid accumulation in the suprapatellar bursa above the kneecap, often due to trauma, inflammation, infection, or degenerative joint disease). The physician was notified and ordered transfer to the hospital for evaluation. A review of Resident 1's nursing progress notes dated June 11, 2026, at 9:20 (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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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	p.m., revealed the resident was admitted to the hospital due to a left knee fracture. A review of the facility's documentation, Incident Report, completed by Employee E3 on June 11, 2026, at 1:00 p.m., revealed the resident's left knee was slightly swollen and tender to the touch. The same report revealed the resident did not have any injuries. The physician and responsible party were notified. An order from the physician to apply ace wrap (to the left knee) was followed. On June 11, 2026, the resident had increased pain and edema to the left knee; the physician was notified and ordered an X-ray. Further review of the report revealed, An investigation was initiated, and staff was interviewed. No concerns noted. [The resident] did not have any falls or injuries, and no bruising was noted. An interview with licensed nurse Employee E4 was conducted on June 29, 2026, at 11:30 a.m. Employee E4 reported that they were Resident 1's full-time nurse. They reported that Resident 1 does not talk and was dependent on all ADL's (Activities of Daily Living). Employee E4 reported that Resident 1 had a companion that stayed with the residents from Monday until Friday, morning until after lunch. Employee E4 reported that on the morning of June 10, 2026, the companion informed them that Resident 1 had pain when moved and repositioned. Employee E4 reported that they visually checked the resident and did not observe signs of pain; the resident was medicated with Tramadol. An observation conducted on June 29, 2026, revealed Resident 1 was roommate with Resident 2. A review of Resident 2's quarterly MDS dated [DATE], revealed that the resident was cognitively intact. A review of the facility's documentation and investigation of Resident 1's left knee fracture of unknown origin revealed that eight statements from the staff (assigned to the resident) did not have their signatures. Further review revealed the resident's roommate, who was alert and oriented was not interviewed. Furthermore, the resident's companion who was with the resident five times a week every morning and the one who reported the pain to Employee E4 on June 10, 2026, was not interviewed. The above findings were conveyed to the Director of Nursing and the Nursing Home Administrator on June 29, 2026, at 1:00 p.m. The NHA confirmed that Resident1's roommate and companion should have been interviewed. The facility failed to ensure Resident 1's left knee fracture of unknown origin was comprehensively investigated. 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on review of facility's policy, clinical records review and staff interviews, it was determined that the facility failed to comprehensively and accurately assess pain and provide pain management for one of two residents reviewed (Resident 1). Findings:A review of the facility's policy titled Pain Management, revised date May 2024, revealed Procedure in recognizing pain: Observe the resident during rest and movement for physiologic and behavioral (nonverbal) signs of pain. Evaluating pain: During the pain evaluation gather the following information; characteristic of pain (1) Intensity of pain (as measured on a standard pain scale) (2) description of pain (3) pattern of pain (4) location of pain and (5) frequency, timing and duration of pain. The same policy revealed Implement the medication regimen as ordered, documenting the results of the intervention.A review of Resident 1's diagnosis list includes Cerebral Vascular Accident (CVA- An interruption in the flow of blood to cells in the brain), Alzheimer's disease (irreversible, progressive degenerative disease of the brain, resulting in loss of reality contact and functioning ability), Seizure Disorder (neurological conditions characterized by recurring unprovoked seizures) and Osteoporosis (A chronic bone disease that causes bones to become porous, brittle, and highly susceptible to fractures from minor falls or daily activities.A review of Resident 1's quarterly Minimum Data Set (MDS- A standardized assessment tool that measures health status in long-term care residents) dated May 11, 2026, revealed resident had severe cognitive impairment and was dependent on all ADL's (activities of daily living).The facility utilizes PAINAD (Pain Assessment in Advanced Dementia- an observation tool used by healthcare providers and caregivers to evaluate pain levels in patients with advanced dementia or severe cognitive impairments who cannot verbally communicate their pain) pain assessment tool. 0 is no pain, 1 to 3 - mild pain, 4-6 - moderate pain, and 7-10 - severe pain.A review of Resident 1's nursing progress notes documented by the unit manager, licensed nurse Employee E3 dated June 9, 2026, at 2:24 p.m., revealed Received in report this resident had left hip pain, resident does flinch when I touch left knee, [they] has slight edema to left knee it is not red, no discharge, no odor, clean, dry and intact. [They] had Hemiplegia (paralysis of one side of the body) and Hemiparesis (weakness or partial loss of movement on one entire side of the body), notified MD (physician). The pain assessment conducted by Employee E3 did not indicate intensity/scale of the pain.An interview with Employee E3 was conducted on June 29, 2026, at 10:45 a.m. Employee E3 reported that on June 9, 2026, at 10:30 a.m., they checked Resident 1 who was already in the wheelchair. Employee E3 reported that the residents' left hip was ok but flinched when knee was touched. Employee E3 further reported that the knee was swollen. The physician was notified and ordered ace wrap to the left leg and to elevate the leg. When asked if pain medication was administered, Employee E3 responded I told the nurse of the pain and [they] would have given the medication. Employee E3 was unable to say who was the nurse they talked to.A review of Resident 1's physician's order revealed resident had an existing (ordered on February 1, 2026) order for Tramadol (A medication used to treat moderate to moderately severe pain) HCL 50 mg give 1 tablet by mouth every six hours as needed for pain.A review of Resident 1 June 2026, Medication Administration Record (MAR) revealed Resident 1 was not administered with as needed Tramadol for the left leg pain on June 9, 2026. A review of Resident 1's June 2026, MAR revealed resident was administered with as-needed Tramadol for a pain level of 3 (mild pain) on June 10, 2026, at 10:14 a.m. The pain assessment did not indicate the pain location.An interview with licensed nurse Employee E5 was conducted on June 29, 2026, at 12:30 p.m. Employee E5 reported that in the morning of June 10, 2026, Resident 1's companion approached them and reported that the resident was in pain when they moved and repositioned the resident. Employee E5 reported I came to check (the resident) and gave [them] the Tramadol. Employee E5 reported that the resident did not have pain, but they also confirmed that they did not touch/move the resident during the assessment, despite the companion's report that the pain was observed when the resident was moved and repositioned. The above findings were conveyed with the Director of Nursing and Nursing Home (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator on June 29, 2026, at 1:00 p.m.The facility failed to ensure Resident 1's pain was comprehensively and accurately assessed, and managed. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing service 28 Pa Code 211.5(f) Clinical Records 28 PA Code 211.10(a) Resident care policies