

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395896	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Homewood Living Martinsburg, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 437 Givler Drive Martinsburg, PA 16662	
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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of clinical records as well as staff interviews, it was determined that the facility failed to notify the resident and resident representative in writing regarding the reason for hospitalizations, for four of 37 residents reviewed (Resident's R9, R37, R76 and R110). Findings include: The facility's policy for Admission, Transfer and Discharge Notification, dated January 8, 2025, did not indicate that upon transfer to the hospital the resident and legal guardian would be notified in writing. An admission MDS for Resident 9, dated October 19, 2025, indicated that the resident was cognitively impaired and had an indwelling urinary catheter (tube placed in the bladder to drain urine). A nurse's note for Resident 9, dated October 29, 2025, at 7:53 a.m. revealed that the resident was sent to the emergency room for an evaluation related to not being able to urinate and unsuccessful attempts to straight catheterize (medical device used to temporarily drain urine from the bladder) him. There was no documented evidence that written notification of transfer to the hospital was provided to Resident 9 or his representative. A quarterly MDS assessment for Resident 37, dated October 9, 2025, indicated that the resident was cognitively intact, required assistance from staff for all daily care needs, and had diagnoses that included congestive heart failure. A nursing note for Resident 37, dated July 3, 2025, revealed the resident was transferred to the hospital following a change in condition. There was no documented evidence in Resident 37's clinical record to indicate that the resident and resident's representative were notified in writing of the purpose for the transfer to the hospital. A quarterly Minimum Data Set assessment for Resident 76, dated October 31, 2025, indicated that the resident was cognitively impaired, required assistance from staff for her daily care needs and had diagnoses that included Alzheimer's disease. Review of Resident 76's clinical record revealed the resident was transferred to the hospital on March 20, 2025 following a fall with injury. There was no documented evidence in Resident 76's clinical record to indicate that the resident and resident representative were notified in writing of the reason for the resident's transfer to the hospital on March 20, 2025. An admission Minimum Data Set assessment for Resident 110, dated September 7, 2025, indicated that the resident was cognitively intact, required assistance from staff for his daily care needs and had diagnoses that included a total hip replacement. Review of Resident 110's progress notes revealed that the resident was transferred to the hospital on September 21, 2025, when he developed a temperature, cough and shortness of breath. There was no documented evidence in Resident 110's clinical record to indicate that the resident and resident representative were notified in writing of the purpose for the resident's transfer to the hospital on September 21, 2025. Interview with the Director of Admissions on December 11, 2025 at 10:45 a.m. confirmed that the facility is not automatically sending written notification to the resident and resident representative when a resident is transferred to the hospital. Interview with the Director of Nursing on December 11, 2025 at 16:30 a.m. confirmed that there is no documentation that the resident and resident representative were notified in writing of Resident 9, 37, 76 and 110's transfers to the hospital, and there should have been. 28 Pa Code: 201.25 Discharge policy. 28 Pa Code: 201.29 (f) Resident rights. 28 Pa Code: 201.29 (g) Resident rights		

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and staff interviews, it was determined that the facility failed to provide a homelike environment for one of 37 residents reviewed (Resident 14). Findings include: The facility's policy entitled Homelike Environment, dated January 8, 2025, indicated that residents will be provided with a safe, clean comfortable and homelike environment. Observations of Resident 14's Broda Chair (a specialized chair designed primarily for individuals with mobility challenges and physical disabilities) on December 8, 2025 at 10:42 a.m.; December 9, 2025 at 1:19 p.m.; and December 10, 2025, at 2:20 p.m. revealed that the resident was resting in her chair and the left armrest had an area approximately 12 inches by 6 inches that was torn and shredded. Interview with Registered Nurse Supervisor 1 on December 10, 2025, at 2:37 p.m. confirmed that the left armrest cover on Resident 14's Broda chair had a large area that was torn and shredding off, and it should not be. Interview with the Director of Nursing on December 10, 2025, at 2:55 p.m. confirmed that Resident 14's Broda chair should not have armrests and/or headrests that are torn or shredded. 28 Pa. Code 201.29(j) Resident Rights. 28 Pa. Code 207.2(a) Administrator's Responsibility.		

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to obtain laboratory studies as ordered by the physician for one of 39 residents reviewed (Resident 17). Findings include: The facility's laboratory and diagnostic test policy, dated January 8, 2025, indicated that the physician would identify and order diagnostic and laboratory testing based on the resident's diagnostic and monitoring needs. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 17, dated November 17, 2025, revealed that the resident was moderately cognitively impaired and had diagnoses that included hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone). Physician's orders for Resident 17, dated November 25, 2025, included an order for staff to obtain a TSH (Thyroid Stimulating Hormone - test used to identify the amount of hormones secreted by the thyroid). There was no documented evidence that staff obtained Resident 17's TSH as ordered on November 25, 2025. Interview with the Director of Nursing on December 11, 2025, at 11:29 a.m. confirmed that there was no documented evidence that Resident 17's TSH level was obtained as ordered by the physician. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.		