STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395913	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntingdon Skilled Nursing and Rehabilitation Cent	3430 Huntingdon Pike Huntingdon Valley, PA 19006

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, it was determined that the facility failed to develop and/or implement a baseline care plan that addressed individual resident needs for three of 20 sampled residents. (Residents 10, 13, 19)Findings include: Clinical record review revealed that Resident 10 was admitted to the facility on [DATE], with diagnoses that included diabetes, heart failure, and muscle weakness. The baseline care plan dated July 16, 2025, noted that the resident was incontinent of bowel. There was no evidence that the care plan included interventions and goals to address Resident 10’s incontinence. Clinical record review revealed that Resident 13 was admitted to the facility on [DATE], with diagnoses that included diabetes and dysphagia (difficulty swallowing). There was no documented evidence that the facility developed a baseline care plan following admission. Clinical record review revealed that Resident 19 was admitted to the facility on [DATE], with diagnoses that included depression and diabetes. On July 22, 2025, a nurse noted that the resident had a language barrier and had difficulty communicating. On July 23, 2025, the social worker documented that the resident's family was required to translate due to a language barrier. There was no documented evidence that the resident's language barrier was addressed in the baseline care plan. In an interview on July 28, 2025, at 4:15 p.m., the Director of Nursing confirmed there was no documented evidence that the care areas were addressed in the resident's baseline care plan. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to develop a comprehensive care plan that addressed individualv resident needs as identified in the comprehensive assessment for one of 20 sampled residents. (Resident 18) Findings include: Clinical record review revealed that Resident 18 was admitted to the facility on [DATE], and had diagnoses that included diabetes, heart failure, and dementia. The Minimum Data Set assessment and Care Area Assessment summary dated July 21, 2025, noted that the resident's urinary incontinence, dental care, self-care, mobility, and pressure ulcer were to be addressed in the care plan. There was no evidence that interventions to address Resident's 18 urinary incontinence, dental care, self-care, mobility, and pressure ulcer were included in the care plan. In an interview on July 28, 2025, at 4:00 p.m., the Director of Nursing confirmed there was no documented evidence that the care areas were addressed in the care plan. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **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 ensure physician's orders were implemented for two of 20 sampled residents. (Residents 1, 16) Findings include: Review of the policy entitled, Medication Administration, last reviewed July 25, 2025, revealed staff were to obtain vital signs as necessary prior to medication administration and document physician indicated medication administration information. Clinical record review revealed that Resident 16 had diagnoses that included hypertension (high blood pressure), heart failure, anemia (blood disorder), and kidney disease. On July 18, 2025, the physician ordered staff to administer a blood pressure medicine (hydralazine HC1) twice a day and once at bedtime. Staff was not to administer the medication if the resident's systolic blood pressure (the first measurement of blood pressure when the heart beats and the pressure is at its highest) was less than 100 millimeters of mercury (mmHg). Review of Resident 16’s July 2025 Medication Administration Record revealed that staff administered the medication 28 out of 29 times with no documented evidence that the blood pressure was assessed prior to medication administration per the physician's order. Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses that included hypertension (high blood pressure), atrial fibrillation (irregular heartbeat), and dysphagia (difficulty swallowing). On July 14, 2025, the physician ordered for staff to obtain the resident's weight daily. There was no documented evidence that staff obtained Resident 1's weight on July 16, 18, 25, or 26, 2025. In an interview on July 28, 2025, at 4:15 p.m., the Director of Nursing confirmed there was no documented evidence Resident 16's blood pressure was taken prior to medication administration, and that Resident's 1's weight was taken daily as per physician's order. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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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 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, it was determined that the facility failed to dispose of trash and refuse properly. Findings include: Observation of the dumpster area on July 28, 2025, at 10:30 a.m., revealed three full trash bags outside the dumpster and a used disposable glove on the ground. The top lid of the garbage dumpster was open and it was full of trash bags. 28 Pa Code 201.18(b)(3) Management.