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	04/03/2026

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on facility policy review, staff interview, and observation, it was determined that the facility failed to monitor dish machine sanitizing solution to ensure that food was served in a sanitary manner. Findings include:Review of the facility policy entitled, Machine Warewashing and Sanitizing, dated March 31, 2026, revealed that for a low temperature dish machine, the appropriate amount of chlorine sanitizing solution is 50 parts per million (PPM). Staff were to record the sanitizer PPM at a minimum of daily on the Dish Machine Daily Temperature Record Log. In an interview during the kitchen tour on April 1, 2026, at 10:14 a.m., the Dietary Manager (DM) stated that the dish machine required a chemical solution to sanitize the dishware. Observation of the dish machine revealed the chemical solution was connected to it during the dishware washing service for breakfast. There were no chemical test strips available in the dietary department for staff to monitor the concentration of the sanitizing solution in the dish machine. Review of the March 2026 Dish Machine Daily Temperature Record Log revealed there was no documented evidence that staff were monitoring the sanitizer PPM daily. In an interview on April 1, 2026, at 2:25 p.m., the DM confirmed that there was no documented evidence that the PPM was being checked daily by staff and it should have been documented on the Daily Temperature Log. 28 Pa. Code 201.14(a) Responsibility of licensee.

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, observation, and staff interview, it was determined that the facility failed to ensure physicians' orders were implemented for four of 20 sampled residents. (Residents 5, 8, 83, and 98)Findings include: Review of the facility policy entitled, Medication Administration General Guidelines, last reviewed March 31, 2026, revealed that staff were to obtain and record vital signs, if necessary, prior to medication administration and document necessary information in the Medication Administration Record (MAR). Clinical record review revealed that Resident 5 had diagnoses that included heart disease and hypertension (high blood pressure). A physician's order dated July 26, 2025, directed staff to administer a medication (metoprolol tartrate) one time a day to treat hypertension. Staff were to hold the medication if the resident's heart rate was below 60 beats per minute. Review of Resident 5's February and March 2026 MAR revealed no documented evidence that the heart rate was taken prior to the medication being administered. Clinical record review revealed that Resident 8 had diagnoses that included dementia and constipation. A physician's order dated January 21, 2026, directed staff to administer a bisacodyl suppository rectally every 24 hours as needed if no bowel movement in two days. Physician's orders dated November 25, 2025, directed staff to administer 17 grams of MiraLax in four to eight ounces of fluid and to administer 30 milliliters of Milk of Magnesia (MOM) as needed at bedtime if the resident has not had a bowel movement in three days. Review of bowel movement tracking documentation for Resident 8 revealed that there were no bowel movements recorded from March 6, 2026, at 9:29 p.m., through March 10, 2026, at 1:49 p.m., and March 27, 2026, at 2:59 p.m., to April 1, 2026, at 9:06 p.m. Review of the MAR for March 2026, revealed that the resident was not provided with any as needed medications for constipation until MOM was provided on night shift April 1, 2026. For both time periods, Resident 8 did not have a bowel movement for at least three days. Clinical record review revealed that Resident 83 had diagnoses that included hypertension. A physician's order dated March 4, 2026, directed staff to administer a blood pressure medication (metoprolol) two times a day. The physician ordered that staff were not to administer the medication if the resident's systolic blood pressure (SBP, the first measurement of blood pressure when the heart beats and the pressure is at its highest) was lower than 110 millimeters of mercury (mm/Hg) or if the heart rate was less than 60 beats per minute. Review of Resident 83's MAR for March 2026 revealed that the staff administered Metoprolol three times when Resident 83's SBP was lower than 110 mm/Hg. Clinical record review revealed that Resident 98 was admitted to the facility on [DATE], following a hospitalization with diagnoses that included shortness of breath, pneumonia, and a new diagnosis of lung cancer. Resident 98's discharge instructions from the hospital dated January 22, 2026, noted the presence of metastatic lung cancer, indicated that an oncologist had been consulted, and the resident needed imaging studies completed that included a position emission tomography (PET) scan to determine the staging of the lung cancer. Resident 98 was to follow up with the oncologist after imaging studies were completed. A letter from the hospital dated January 21, 2026, confirmed that Resident 98 was scheduled for a PET Scan on February 4, 2026, at 9:15 a.m. A physician's progress note dated January 28, 2026, noted the facility was aware that Resident 98 had metastatic lung cancer and needed an outpatient PET scan to be completed per oncology's recommendation. A general progress note dated February 5, 2026, indicated a PET scan was re-scheduled for February 13, 2026, at 1:45 p.m. A physician's progress note, dated February 9, 2026, confirmed that Resident (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	98's appointment for the PET scan had been rescheduled. There was lack of evidence to support that the facility transported the resident to the scheduled appointment for the PET scan on February 13, 2026. There was no indication that the appointment was rescheduled prior to the resident's emergency transfer to the hospital on February 19, 2026. In interviews on April 2, 2026, at 11:09 a.m., 11:45 a.m., and 12:24 p.m., and on April 3, 2026, at 12:16 p.m., the Regional Clinical Director confirmed there was no documented evidence that the blood pressure and heart rate were taken prior to medication administration per physician's order for Resident 5, that none of the as needed medications for constipation were administered to Resident 8 and should have been, that Resident 83 received the medication outside of the ordered parameters, and that Resident 98 did not get the PET scan as scheduled on February 13, 2026, and the appointment was not rescheduled. CFR 483.25 Quality of CarePreviously cited 7/28/25 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on clinical record review and staff interview, it was determined that the facility failed to ensure that residents were free from potential chemical restraints for one of five sampled residents who were ordered psychotropic medications. (Resident 8)Findings include:Clinical record review revealed that Resident 8 had diagnoses that included anxiety and dementia. On January 21, 2026, a physician ordered staff to administer an anti-anxiety medication (lorazepam) every six hours as needed for end-of-life anxiety and terminal agitation. The order did not include a date to indicate when staff were to stop administering the as needed medication. Review of Resident 8's Medication Administration Record revealed that staff had administered the lorazepam 14 times in February 2026 and five times in March 2026. There was no documented evidence that the physician had reevaluated continued use beyond 14 days of the as needed anti-anxiety medication. In an interview on April 2, 2026, at 11:08 a.m., the Regional Clinical Director confirmed that the physician's order did not include when staff were to stop administering the as needed anti-anxiety medication. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined that the facility failed to complete an accurate Minimum Data Set (MDS) assessment for two of 20 sampled residents. (Residents 11 and 67)Findings include: Clinical record review revealed that Resident 11 had diagnoses that included Parkinson's disease (a progressive, incurable neurological disorder) with dyskinesia (involuntary, erratic, writhing, or jerky movements caused by long term use of medication to treat Parkinson's disease), dementia, and repeated falls. A review of nurses' notes indicated that the resident had falls on December 24, 2025, December 25, 2025, December 29, 2025, and January 26, 2026. A review of Resident 11's MDS assessment dated [DATE], incorrectly indicated in Section J (falls since admission/entry or reentry, or prior assessment whichever is more recent) that the resident had not fallen since the prior assessment which had been completed on November 24, 2025. Clinical record review revealed that Resident 67 had diagnoses that included Alzheimer's disease and anxiety. A physician's order dated December 30, 2025, ordered staff to apply a wander guard bracelet (a wearable device designed to prevent residents from unsafe wandering) to the resident's left ankle. A review of Resident 67's MDS assessment dated [DATE], section P (alarms not used, used less than daily, or used daily) incorrectly indicated that a wander alarm was not used. Observation on March 31, 2026, at 2:00 p.m. revealed a wander guard bracelet on the resident's left ankle. In an interview on April 2, 2026, at 2:28 p.m., the Regional Clinical Director confirmed that Resident 11's MDS completed on February 17, 2026, was inaccurate and should have captured four falls and that Resident 67's MDS completed on February 12, 2026, should have indicated that a wander alarm was used daily.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and resident and staff interviews, it was determined that the facility failed to provide services to maintain adequate grooming and hygiene for one of 20 sampled residents. (Resident 5)Findings include: Clinical record review revealed that Resident 5 had diagnoses that included cerebral palsy, muscle weakness, and depression. A Minimum Data Set (MDS) assessment dated [DATE], revealed that Resident 5 required maximum assistance with hygiene and self-care and had no cognitive impairment. Review of the care plan revealed that staff were to assist the resident with hygiene and self-care. On March 31, 2026, at 1:20 p.m., the resident was observed in his room. His nails were long and dirty. In an interview at that time, he stated that he would like his nails cleaned and that he would not refuse nail care on his bath day since his nails were dirty. Documentation revealed that Resident 5 was last bathed by staff on March 30, 2026, and he had not refused care. On April 1, 2026, at 10:45 a.m., the resident was observed in his bed. His nails remained long with dirt underneath them. In an interview on April 2, 2026, at 11:07 a.m., the Regional Clinical Director confirmed that nail care was to be done on shower days as needed. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide restorative nursing services to increase or prevent a reduction in range of motion for one of 20 sampled residents. (Resident 6)Findings include:Clinical record review revealed that Resident 6 had diagnoses that included quadriplegia (paralysis of all four limbs), muscle weakness, and left-hand contracture (a condition where the tissues of the hand stiffen and tighten and limits hand mobility). The Minimum Data Set assessment dated [DATE], indicated that the resident was severely cognitively impaired, was dependent on staff for personal hygiene, and had a loss of range of motion in the upper extremities. On January 27, 2026, the occupational therapist had recommended a palm guard splint due to left hand contracture management. A physician's order dated January 27, 2026, directed that staff were to apply a left palm guard splint after morning care was provided and then remove it after evening care was provided every day. On March 26, 2026, a restorative nursing note stated that the resident continued to require the left palm splint. Observations on April 1, 2026, at 9:44 a.m., and April 2, 2026, at 10:35 a.m., revealed that Resident 6 was lying in bed with his left hand in a clenched fist without a left palm guard splint in place. Morning care had previously been provided to the resident at the time of both observations. In an interview on April 2, 2026, at 10:40 a.m., Registered Nurse (RN) 1 confirmed that Resident 6 was to have the left palm guard splint and could not locate it in his room.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, review of facility documentation, clinical record review, and staff interview, it was determined that the facility failed to implement adequate interventions to prevent falls for one of 20 sampled residents. (Resident 11)Findings include: Review of the facility policy entitled, Accidents/Incidents, last reviewed March 31, 2026, revealed that an appropriate intervention would be implemented based on the conclusion of an accident or incident investigation. Clinical record review revealed that Resident 11 had diagnoses that included Parkinson's disease (a progressive, incurable neurological disorder) with dyskinesia (involuntary, erratic, writhing, or jerky movements caused by long term use of medication to treat Parkinson's disease), dementia, and repeated falls. The Minimum Data Set assessment dated [DATE], indicated that the resident was cognitively impaired and dependent on staff for transfers. A review of facility documentation and nurse's notes dated December 25, 2025, indicated that the resident had a witnessed fall in the dining room. There was a lack of documentation to support the resident was assessed for any new interventions or that any additional measures were implemented following the fall. A review of Resident 11's care plan revealed that the resident was at risk for falls, had previous falls, but did not indicate that an intervention was implemented after the resident ?s fall on December 25, 2025. The resident had additional falls on December 29, 2025, and January 26, 2026. In an interview on April 3, 2026, at 9:32 a.m., the Director of Nursing confirmed that there was no documented evidence that an additional intervention was implemented after Resident 11's fall on December 25, 2025. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on facility policy review, observation, and staff interview, it was determined that the facility failed to ensure staff implemented infection control policies to prevent the spread of infection for three of 20 residents sampled. (Residents 36, 53, and 99) Review of the facility policy entitled, Medication Administration, last reviewed March 31, 2026, revealed that staff were to complete appropriate hand hygiene prior to preparing or administering medications to the residents. On April 1, 2026, at 8:18 a.m., Licensed Practical Nurse (LPN) 1, was observed administering medications to Residents 36, 53, and 99. The LPN did not perform hand hygiene prior to administering medications to the residents. In an interview on April 3, 2026, at 9:40 a.m., the Director of Nursing confirmed that LPN 1 should have completed hand hygiene prior to administering medications to Residents 36, 53, and 99. 28 Pa. Code 211.12(d)(1)(5) Nursing services