

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: 395927	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2025
NAME OF PROVIDER OR SUPPLIER Stoneridge Poplar Run		STREET ADDRESS, CITY, STATE, ZIP CODE 450 East Lincoln Avenue Myerstown, PA 17067	
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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on clinical record review and staff interview, it was determined that the facility failed to ensure that a Minimum Data Set assessment for a significant change in condition was completed for one of 14 sampled residents. (Resident 2) Findings include: Clinical record review revealed that Resident 2 experienced a decline in overall status and hospice services began on October 17, 2025. There was no Minimum Data Set (MDS) assessment completed to reflect the significant change in the resident's condition. In an interview on November 14, 2025, at 10:29 a.m., the Administrator confirmed that a significant change MDS assessment was not completed upon a change in the resident's condition.		

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the Minimum Data Set (MDS) assessment was completed to accurately reflect the resident's current status for one of 14 sampled residents. (Resident 7) Findings include: Clinical record review revealed that Resident 7 had diagnoses including Parkinson's disease, dementia, dysphagia following cerebral infarction (stroke), moderate protein-calorie malnutrition, and gastro-esophageal reflux disease with esophagitis without bleeding. On September 12, 2025, a physician ordered for staff to provide a regular, mechanical soft diet. Review of the MDS assessment dated , August 15, 2025, revealed that the resident received nutrition through a tube feed. There was no documented evidence that Resident 7 received nutrition through a tube feed. In an interview on November 14, 2025, at 12:20 p.m., the Administrator confirmed that the MDS assessment did not accurately reflect the nutrition status of Resident 7.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, observation, and staff interview, it was determined the facility failed to store food in a sanitary manner on one of two nursing units. (Health Care 1) Findings include: Review of the facility policy entitled, Use and Storage of Food Brought in by Family or Visitors, dated July 24, 2025, revealed that nursing staff were to label and date the resident food items that required refrigeration. Observation on Health Care 1 in the resident pantry on November 13, 2025, at 2:15 p.m., revealed a sign on the refrigerator that indicated it was for resident food only, items should be dated and labeled with the resident's name, and would be discarded within three days if not consumed. In the freezer, there were two opened containers of ice cream and two opened boxes of ice cream popsicles that were not dated or labeled with a resident name. In the refrigerator, there were three juice boxes, one Boost drink and a six-pack of soda that were not labeled with resident names. There was a plastic zip-lock bag that contained cookies on top of another container, neither were dated or labeled with a resident name. There was one opened bottle of orange drink dated October 19, a container of pink grapefruit that was not dated, and a container of spaghetti that was not labeled with a resident name. There were two boxes of candy that were not dated. There were two opened containers of lemonade that were not labeled or dated. In an interview on November 14, 2025, at 12:20 p.m., the Administrator confirmed the refrigerator is for resident food only and that staff were to date and label the items with the resident's name. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(3)(e)(2.1) Management.		

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on review of facility documents and staff interview, it was determined that the facility failed to ensure that all the required committee members attended quarterly Quality Assurance and Performance Improvement (QAPI) meetings for three of four quarters of meetings reviewed. Findings include: Review of facility's QAPI sign-in sheets and attendance records for meetings held in the fourth quarter of 2024 revealed that the facility's Infection Preventionist and Medical Director failed to attend. Review of the facility's QAPI sign-in sheets and attendance records for the first three quarters of 2025 revealed the facility's Medical Director failed to attend meetings held during the second and third quarters of 2025. During an interview on November 12, 2025, at 12:10 p.m., the Administrator confirmed that the facility failed to ensure that all the required committee members attended QAPI meetings at least quarterly. 28 Pa Code: 201.18(e)(1)(2)(3) Management.		

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review and staff interview, it was determined that the facility failed to provide a written notice of the facility's bed-hold policy (an agreement for the facility to hold a bed for an agreed rate during a hospitalization) and notice of transfers out of the facility to the State Long-Term Care Ombudsman and to the resident, family member, or legal representative for four of four sampled residents who were transferred to a hospital. (Residents 3, 11, 14, and 20) Clinical record review revealed that Resident 3 was transferred to the hospital on July 18, 2025, after a change in condition. There was no documented evidence to support that the resident and/or the resident's responsible party or legal representative was provided with written information regarding facility's bed hold policy or the transfer to the hospital and that the facility notified the Office of the State Long-Term Care Ombudsman. Clinical record review revealed that Resident 11 was transferred to the hospital on December 9, 2024, and October 6, 2025, after changes in condition. There was no documented evidence to support that the resident and/or the resident's responsible party or legal representative was provided with written information regarding the facility's bed hold policy or transfers to the hospital and that the facility sent copies of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman. Clinical record review revealed that Resident 14 was transferred to the hospital on January 31, 2025, and February 11, 2025, after changes in condition. There was no documented evidence to support that the resident and/or the resident's responsible party or legal representative was provided with written information regarding the facility's bed hold policy or transfers to the hospital and that the facility notified the Office of the State Long-Term Care Ombudsman. Clinical record review revealed that Resident 20 was transferred to the hospital on September 26, 2025, and October 25, 2025, after changes in condition. There was no documented evidence to support that the resident and/or the resident's responsible party or legal representative was provided with written information regarding the facility's bed hold policy or transfers to the hospital and that the facility notified the Office of the State Long-Term Care Ombudsman. In an interview on November 13, 2025, at 2:36 p.m., the Administrator confirmed no transfer and bed-hold notices were provided to the residents or representatives in the cases listed above.		