

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395939	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Complete Care at Lehigh LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1718 Spring Creek Road MacUnjie, PA 18062	
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 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 observation and staff interview, it was determined that the facility failed to store food in a sanitary manner in the dietary department. Findings include: Observations during the kitchen tour on July 26, 2026, at 10:00 a.m., revealed the following: In the walk-in freezer, there was an accumulation of ice on the floor on the left side of the entry way and on the ceiling on the right side of the fan. In a reach-in refrigerator, there were six trays of pre-poured juices that had no label or date. On July 26 2026, at 10:12 a.m., the Assistant Dietary Manager confirmed that the pre-poured juices should have been labeled and dated. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(3) Management.		

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 - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, it was determined that the facility failed to provide a safe, clean, and comfortable environment on four of four nursing units. (Units TCU, 1A, 2B and 2C) Findings include: Observations on July 26, 2026, from 10:05 a.m. to 1:35 p.m., revealed the following: The inside of the microwave in the TCU's nourishment room had food debris throughout. In room [ROOM NUMBER]-B, there was a brown stain on the ceiling tile near the window. In room [ROOM NUMBER], there were six holes in the wall and a three-foot area of baseboard missing in front of bed A. The dresser for bed A had three broken shelves that were held together with tape. In the bathroom, the wall on the right side was marred and paint was chipped away. In room [ROOM NUMBER], there was a quarter-sized hole in the wall in front of bed A. In the bathroom, there was a stained ceiling tile above the toilet, the wall was marred, and paint was chipped. In room [ROOM NUMBER], there was a substantial amount of rust and peeling paint on the front of the raised toilet seat bar. In room [ROOM NUMBER], there were multiple broken and missing air vents. There was debris inside of the wall unit air conditioner/heater. In room [ROOM NUMBER], the wood flooring was torn between bed A and the wall. Observations on July 27, 2026, from 12:45 p.m. to 1:30 p.m., revealed the following: In room [ROOM NUMBER] B, there were broken window blinds and three ceiling tiles with brown stains. In room [ROOM NUMBER] A, there were brown marks on the wall behind the bed and a brown stain on the ceiling tile to the left of the bed. In the TCU shower room, there were rusty metal ceiling tiles in the first shower stall to the left of the doorway. A mechanical lift was missing a rubber strip on one footrest and the other footrest was rusty. Another mechanical lift was missing a rubber strip on the right side of the footrest. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(2.1) Management.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure that appropriate assistance with bathing and personal hygiene was provided to four of eight sampled residents who required assistance from staff to complete activities of daily living (ADL)s. (Resident 7, 13, 114, 121) Findings include: Clinical record review revealed that Resident 7 had diagnoses that included a bladder cancer, muscle weakness, and polyneuropathy (numbness and tingling to feet and hands due to peripheral nerve malfunction) of the body. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed that Resident 7 required assistance from staff with hygiene and self-care and had severe cognitive impairment. Review of the care plan revealed that staff were to assist the resident with ADLs due to his immobility and bladder cancer. On July 26, 2026, at 1:38 p.m., the resident was observed sitting in his wheelchair. The nails on both hands were dirty, his hair looked messy and unclear, he had an accumulation of white flakes on his shirt and pants, and he had long facial hair. On July 27, 2026, at 12:10 p.m., July 28, 2026, at 1:12 p.m., and July 29, 2026, at 10:10 a.m., the resident was again observed with long facial hair, messy and unkempt hair, and dirt under his nails. Review of the resident's clinical record revealed no evidence that the resident received a shower or bath, hair, nail, or foot care, or facial hair grooming since June 30, 2026. There were no documented resident refusals. Clinical record review revealed that Resident 13 had diagnoses that included anxiety, depression, and dementia. Review of the MDS assessment dated [DATE], indicated that the resident had moderate cognitive impairment and required substantial assistance with bathing and grooming. Review of the care plan revealed that Resident 13 had ADL self-care performance deficits related to confusion and impaired balance. The intervention was for staff to assist with bathing. On July 26, 2026, at 11:48 a.m., July 27, 2026, at 12:15 p.m., July 28, 2026, at 1:00 p.m., and July 29, 2026, at 10:25 a.m., the resident was observed with facial hair on her upper lip and disheveled hair. In an interview on July 28, 2026, at 1:00 p.m., Resident 13 stated she preferred to have showers. Review of the resident's clinical record revealed no evidence that the resident received a shower or bath, hair care, or facial hair grooming since June 30, 2026. There were no documented resident refusals. Clinical record review revealed that Resident 114 had diagnoses that included anxiety, depression, and chronic respiratory failure. Review of the MDS assessment dated [DATE], indicated that the resident had mild cognitive impairment and required substantial assistance with bathing and personal hygiene. Review of the care plan revealed that Resident 114 had ADL self-care performance deficits related to ambulatory dysfunction. An intervention was for staff to assist with bathing. On July 26, 2026, at 12:02 p.m. and July 28, 2026, at 1:25 p.m., the resident was observed in her wheelchair and her hair appeared dirty and unkempt. In an interview on July 28, 2026, at 1:25 p.m., Resident 114 stated that she preferred to have showers and had gone weeks without a shower. Review of the resident's clinical record revealed no evidence that the resident received a shower, bath, or hair care since June 30, 2026. There were no documented resident refusals. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on July 29, 2026, at 11:10 a.m., the Director of Nursing confirmed that there was no documented evidence that staff assisted the residents with the ADLs to maintain proper grooming and hygiene, and they should have. Clinical record review revealed that Resident 121 had diagnoses that included right shoulder rotator cuff tear, diabetes mellitus, obesity, and generalized muscle weakness with need for assistance with personal care. Review of the MDS assessment dated [DATE], revealed that the resident was cognitively intact and was dependent on staff for toileting, personal hygiene, and bed mobility. Review of the care plan revealed Resident 121 had an actual impairment to skin integrity. The intervention was for staff to perform a brief change every two hours and as needed with incontinence. During an interview on July 30, 2026, at 10:17 a.m., Resident 121 reported that his brief was wet and soiled, and proceeded to activate his call bell. At 10:22 a.m., LPN 2 answered Resident 121's call light and said that staff would be back shortly to address his incontinence care, turned off the call bell, and left the room. At 10:51 a.m., the second-floor Unit Manager entered the room and acknowledged Resident 121's request for incontinence care and left the room to find staff. At 10:57 a.m., staff entered Resident 121's room and provided incontinence care, 35 minutes after he requested assistance. In an interview on July 30, 2026, at 11:05 a.m., the Director of Nursing confirmed that incontinence care should be performed timely. CFR 483.24(a)(2) ADL Care Provided for Dependent Residents Previously cited 8/21/25. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **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 assess a resident's capability to self-administer medications for two of 28 sampled residents. (Residents 5 and 10) Findings include: Review of the facility policy entitled, Resident Self-Administration of Medication, last reviewed June 4, 2026, revealed that a resident was only to self-administer medications after the facility's Interdisciplinary Team had determined which medications may be self-administered safely. It was the responsibility of the Interdisciplinary Team to determine the following issues with regards to resident self-administration of medications: the medications appropriate and safe for self-administration; the resident's physical capacity to swallow without difficulty, open medication bottles, and administer injections; the resident's cognitive status, and the resident's ability to ensure that medication is stored safely and securely. The results of the Interdisciplinary Team assessment would be recorded in Self Administration of Medication Assessment. Clinical record review revealed that Resident 5 was admitted to the facility on [DATE], had diagnoses that included paraplegia (paralysis of the legs and lower body caused by a problem with the spinal cord or nerves), Parkinson's disease, and chronic pain syndrome. Review of the Minimum Data Set (MDS) assessment, dated May 10, 2026, revealed that Resident 5's cognitive ability was intact and the resident was dependent on staff for activities of daily living, including toileting, dressing, and personal hygiene. Observation on July 29, 2026, at 10:34 a.m., revealed a tube of antifungal cream (Ketoconazole 2% cream) and a bottle of scalp oil (Derma-Smoothe/Fluocinolone Acetonide 0.01 percent) unsecured on the bedside table in Resident 5's room. Resident 5 stated that he self-administered both prescribed medications as needed for the rash on his face and scalp. The medications were not secured in his room. In an interview on July 29, 2026, at 2:37 p.m., the Director of Nursing confirmed Resident 5 was not assessed to self-administer the medications as per the facility policy. Clinical record review revealed that Resident 10 was admitted to the facility on [DATE], had diagnoses that included dementia, hallucinations, mild cognitive impairment, atrial fibrillation (irregular heart rhythm that starts with fast, chaotic electrical signals in the upper chambers of the heart), and high blood pressure. Review of the MDS assessment, dated June 4, 2026, revealed Resident 10's cognitive ability was intact. Observation on July 27, 2026, at 9:37 a.m., revealed that Resident 10 took his prescribed medications in his room, without a nurse present. In an interview during the observation period, the resident stated that he was taking his five scheduled morning medications. A physician order dated September 14, 2024, revealed that Resident 10 may not administer his own medications. There was a lack of evidence to support that the Interdisciplinary Team had assessed the resident to self-administer medications. In an interview on July 27, 2026, at 10:05 a.m., licensed practical nurse (LPN) 1 confirmed she left the medications at Resident 10's bedside and left the room. In an interview on July 27, 2026, at 10:10 a.m., the nurse unit manager confirmed Resident 10 did not have an order to self-administer medications. In an interview on July 28, 2026, at 2:00 p.m., the Director of Nursing confirmed Resident 10 was not assessed to self-administer the medications as per the facility policy. CFR S483.10 (c)(7) Resident Self-Admin Meds-Clinically Appropriate Previously cited 8/21/25. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that a call system was accessible for one of 28 sampled residents. (Resident 21) Findings include: Clinical record review revealed that Resident 21 had diagnoses that included high blood pressure, prostate cancer, generalized muscle weakness, and chronic obstructive pulmonary disease (COPD). Review of the Minimum Data Set (MDS) assessment, dated May 11, 2026, revealed Resident 21's cognitive ability was intact, and the resident was dependent on staff for activities of daily living, including toileting, dressing, and personal hygiene. Review of the care plan revealed that Resident 21 was at risk for falls with an intervention for staff to be sure the resident's call light was within reach to use for assistance as needed. Observations on July 26, 2026, at 12:31 p.m., July 27, 2026, at 10:20 a.m. and 12:40 p.m., July 28, 2026, at 10:04 a.m. and 1:05 p.m., Resident 21 was observed in bed, the call system device was tucked inside the top drawer of his nightstand table, out of the resident's reach. In an interview on July 28, 2026, at 2:00 p.m., the Director of Nursing confirmed that the resident's call system device should have been placed within the resident's reach. 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 facility policy review, clinical record review, and resident and staff interviews, it was determined that the facility failed to implement interventions to prevent further decline and/or improve range of motion for three of 28 sampled residents with limited range of motion. (Residents 4, 13, 84) Findings include: Review of the facility policy entitled, Restorative Nursing Documentation, last reviewed on June 1, 2026, revealed that staff were to document treatment in the medical record daily or as described in the resident's care plan, were to include the number of minutes the treatment was performed, and if the treatment was refused or withheld. Clinical record review revealed that Resident 4 had diagnoses that included muscle weakness, epilepsy, and depression. The Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident had moderate cognitive impairment, had impaired range of motion (ROM) of the bilateral upper extremities, was dependent on staff for personal hygiene and dressing, and had a restorative nursing program in place for active and passive ROM exercises. According to the care plan, the resident was at risk for limitations of movement and contractures due to muscle weakness. The intervention was for staff to provide active and passive ROM exercises to her upper and lower extremities. On June 11, 2026, a nurse noted that Resident 4 was to continue to participate in a ROM restorative nursing program to prevent contractures that included active assisted ROM to right upper extremity and passive ROM to the left upper extremity and that she was tolerating it well. The exercises included abduction and adduction of the shoulder, and flexion and extension of the elbow, wrist, and hand joints. There was a lack of documentation to support that staff performed the ROM exercises for nine of 30 days from June 29, 2026, through July 28, 2026. There were no documented resident refusals. In an interview on July 26, 2026, at 10:55 a.m., Resident 4 stated that staff did not assist her with exercises regularly and that she wanted to do the exercises to maintain her mobility. Clinical record review revealed that Resident 13 had diagnoses that included anxiety, depression, and dementia. The MDS assessment dated [DATE], indicated that the resident had moderate cognitive impairment, needed set up assistance for most activities of daily living (ADLs), required substantial assistance with bathing, and had a restorative nursing program in place for staff to assist her with active ROM exercises. According to the care plan, the resident was at risk for limitations of independent movement due to generalized muscle weakness. The intervention was for staff to provide active ROM to her bilateral upper and lower extremities. On June 11, 2026, a nurse documented that Resident 13 was to continue to participate in ROM restorative nursing program to maintain strength and mobility for transfers and ADLs and staff were to assist with active ROM exercises to the bilateral upper and lower extremities. The exercises included bilateral flexion and extension of the elbows, wrists, and hands, and abduction and adduction of bilateral shoulders for one set of ten repetitions, and bilateral kicking legs out, moving legs to side, lifting knees up, and moving feet up and down while seated for three sets of ten repetitions for the lower extremities. Review of nursing documentation revealed no evidence that staff performed the ROM exercises for ten of 30 days from June 29, 2026, through July 28, 2026. There were no documented resident refusals. In an interview on July 29, 2026, at 10:32 a.m., Resident 13 stated that staff did not consistently assist her with exercises and that she needed help from staff to remind her to do her exercises. Clinical record review revealed that Resident 84 had diagnoses that included a below the knee amputation, diabetes, and depression. The MDS assessment dated [DATE], indicated that the resident had no cognitive impairment, had an impaired lower extremity, needed substantial (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance for most ADLs, including bathing and dressing, and had a restorative nursing program in place for staff to assist her with active ROM exercises. According to the care plan, the resident was at risk for limitations of independent movement due to muscle weakness and a right below the knee amputation. The intervention was for staff to provide cues, reminders, and physical assistance as needed to assist the resident with prescribed exercises. On June 11, 2026, nursing documentation indicated that Resident 84 was to continue on a ROM restorative nursing program that included active ROM exercises to the bilateral lower extremities to maintain strength and mobility. The exercises included bilateral marching, kicking straight, kicking side, and left lower extremity movement of the ankles up and down for three sets of ten repetitions. Review of nursing documentation revealed no evidence that staff performed the ROM exercises for ten of 29 days from June 30, 2026, through July 28, 2026. In an interview on July 29, 2026, at 11:00 a.m., Resident 84 stated that staff did not provide assistance with exercises, she needed help from staff, and she wanted to exercise her legs. In an interview on July 29, 2026, at 11:37 a.m., the Director of Nursing confirmed that there was no documentation to support that the restorative nursing exercises were completed on the dates listed for Residents 4, 13, and 84, and that they should have been completed. 28 Pa. Code 211.12(d)(1)(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 clinical record review, observation, and staff interview, it was determined that the facility failed to implement safety interventions for one of 28 sampled residents. (Resident 1) Findings include: Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], and had diagnoses that included cerebral infarction (the death of brain tissue caused by a blocked blood vessel), hemiplegia (total paralysis on one side of the body) affecting left dominant side, generalized muscle weakness, and high blood pressure. On July 3, 2025, a physician ordered that staff place padded fall mats to both sides of the resident's bed while the resident was in bed. The Minimum Data Set (MDS) assessment dated [DATE], revealed Resident 1 was dependent and required two staff for assistance with bed mobility and transfers. Review of the care plan revealed that the resident was at risk for falls, had a history of falls, and that staff was to place mats on the floor on both sides of the bed while the resident was in bed. During observations on July 26, 2026, at 11:22 a.m., July 27, 2026, at 11:22 a.m., and July 28, 2026, at 10:02 a.m. and 1:30 p.m., Resident 1 was in bed with only one padded fall mat observed on the right side of the bed. In an interview on July 29, 2026, at 2:00 p.m., the Director of Nursing confirmed that the bilateral padded fall mats were to have been in place. 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. **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 implement enhanced barrier precautions (EBP) and the proper use of personal protective equipment (PPE) to prevent the spread of infection for one of 28 sampled residents. (Resident 41) Findings include: Review of the facility policy entitled, Enhanced Barrier Precautions (EBP), last reviewed June 1, 2026, revealed that EBP were to be used with any high risk resident, including a resident with an indwelling device, during high contact care activities which included catheter care, changing briefs, bathing, dressing, and changing linens. EBP included the use of PPE such as protective gowns and gloves during high-risk activities. Clinical record review revealed that Resident 41 had diagnoses that included neuromuscular dysfunction of the bladder (urinary retention) which required an indwelling catheter, chronic kidney disease, urinary tract infection, and diarrhea. Review of the Minimum Data Set assessment dated [DATE], revealed that Resident 41 had an indwelling catheter, was always incontinent of bowel, and was dependent on staff for catheter care and changing briefs. During an interview on July 26, 2026, at 10:05 a.m., Resident 41 reported that her brief was soiled and needed to be changed. At 10:24 a.m., Nurse Aide (NA) 1 entered Resident 41's room and changed the resident's brief and soiled bed linens. NA 1 did not wear a gown when she provided care. NA 1 left Resident 41's room without changing the soiled gloves or performing hand hygiene and entered Resident 131's room. On July 28, 2026, at 2:45 p.m., the Director of Nursing confirmed that staff should have used appropriate PPE during Resident 41's care and that staff were to remove used gloves prior to exiting a resident room. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		