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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396064 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/04/2025 |
| NAME OF PROVIDER OR SUPPLIER Margaret E. Moul Home | | STREET ADDRESS, CITY, STATE, ZIP CODE 2050 Barley Road York, PA 17404 | |
| 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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on review of clinical records and staff interviews, it was determined that the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) appropriately, in advance of changes for Medicare covered services, to three of three residents reviewed whose Medicare coverage was discontinued (Residents 6, 9, and 66). Findings include: Review of Resident 6 clinical record documented last covered day for Medicare A services was April 10, 2025. Review of progress note dated April 8th, 2025, read, in part, a message was left for Resident 6's parents stating the Medicare services will end on April 10th, 2025, and on April 11th, 2025, she will evert back to Medicaid. Notice of Medicare Non-Coverage (NOMNC) was mailed to Resident 6's parents. The facility provided a copy of the signed NOMNC, which was dated April 11th, 2025. Review of Resident 9's clinical record documented last covered day for Medicare A services was May 6, 2025. Review of progress note, dated May 2nd, read, in part, Resident 9 was notified that his Medicare services will end on May 6th, 2025, and on May 7th, 2025, he will evert back to Medicaid. The Resident had no further questions. The facility provided a copy of the signed NOMNC, which was dated May 2nd, 2025. Review of Resident 66's clinical record documented last covered day for Medicare A services was May 26, 2025. Review of progress noted dated May 23rd, 2025, read, in part, Resident 66 was notified that his Medicare services will end on May 26th, 2025, and on May 27th, 2025, he will evert back to Medicaid. The Resident had no further questions. The facility provided a copy of the signed NOMNC, which was dated May 23rd, 2025. Interview with Employees 1 and 2 on September 4th, 2025, at 11:48 AM, revealed the facility wasn't utilizing the Center for Medicaid/Medicare Services SNF ABN form as of January 2025. It was revealed that they were informed regarding an update to the NOMNC form January 2025 and assumed the SNF ABN form was no longer required. Interview with the Nursing Home Administrator on September 4, 2025, at 12:16 PM, revealed the SNF ABN form should've been completed. 28 Pa. Code 201.29(c.3)(1) 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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>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.</p> <p>Based on clinical record review, observations, and staff interviews, it was determined that the facility failed to ensure a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for one of 19 residents reviewed (Resident 1). Findings include: Review of Resident 1's clinical record revealed diagnoses that included gastrostomy status (a surgical procedure that involves creating an opening in the stomach through the abdominal wall, allowing for the placement of a feeding tube) and cerebral palsy (a neurological disorder that affects body movement and muscle coordination, typically caused by abnormal brain development or damage to the brain). Review of Resident 1's physician orders revealed an order for Bilateral hand rolls worn when OOB (out of bed). Don/Doff by (Nurse Aide), with a start date of April 24, 2024. Review of Resident 1's comprehensive care plan revealed a focus area of Impaired Mobility with potential for contractures (structural changes to your soft and connective tissues that cause them to stiffen, tighten and contract) related to diagnosis cerebral palsy with an intervention for Bilateral hand rolls when out of bed, with a start date of April 22, 2024. Observations of Resident 1 on September 2, 2025, between 9:40 AM and 12:26 PM, revealed he was sitting in his wheelchair and did not have bilateral hand rolls in his hands. Observations of Resident 1 on September 3, 2025, between 9:30 AM and 11:52 AM, revealed he was sitting in his wheelchair and did not have bilateral hand rolls in his hands. Review of Resident 1's clinical record revealed a nurse aide task Apply or remove- Bilateral hand rolls worn when OOB. Further review of the aforementioned nurse aide task revealed documentation to indicate Employee 4 (Nurse Aide) donned the bilateral hand rolls on Resident 1 on September 3, 2025, at 8:48 AM. Interview with Employee 5 (Licensed Practical Nurse) on September 3, 2025, at 12:00 PM, revealed she was unsure as to why Resident 1 did not have his bilateral hand rolls in place, and she was unable to find them in his room. Interview with the Director of Nursing (DON) on September 4, 2025, at 10:06 AM, she revealed Employee 4 stated she put the hand rolls on that morning but then took them off for care and forgot to put them back on, and that an employee from the therapy department went back to the room later that day and found the hand rolls in Resident 1's top drawer in his room. During an email correspondence with the Nursing Home Administrator on September 4, 2025, at 10:53 AM, he revealed his expectation that the bilateral hand rolls would be applied following the physician orders. 28 Pa. Code 211.10 (a) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on facility policy reviews, observations, and staff interviews, it was determined that the facility failed to store food and utilize equipment in accordance with professional standards for food service safety in the main kitchen. Findings include: Review of facility policy, titled Labeling and Dating last reviewed September 2, 2025, read, in part, All food items must be labeled and dated. All food items must be labeled with either a manufacturer label or handwritten label. Review of facility policy titled Purchasing Policy- Storage last reviewed September 2, 2025, read, in part, all items in refrigerators and freezers must be properly wrapped, labeled, and dated. Observation in the dry storage area on September 2, 2025, at 9:57 AM, revealed one open bag of macaroni pasta without an open date; one open bag of penne pasta without an open date; two bags of angel hair pasta not dated; one bag of open powdered sugar not labeled or dated; and one bag of candy topping not labeled or dated. Observation in the walk-in refrigerator on September 2, 2025, at 9:59 AM, revealed one package of vegan cheese left open to air not properly sealed; one container of mozzarella cheese left open to air not properly sealed; two packages of meat revealed to be turkey breast not labeled or dated; one bag of spinach not dated; one bag of parsley not dated; two bags of broccoli not dated; one open container of sour cream open without an open date; and one bag of whipped cream open and not dated. Observation in walk-in freezer unit on September 2, 2025, at 10:04 AM, revealed two packages of zucchini fries not dated; two bags of waffles not dated with one left open to air not properly sealed; and two packages of hot dogs not dated. Observation in the main kitchen on September 2, 2025, at 10:08 AM, revealed a blank temperature log from July 2025 on the wall overtop of the three-compartment sink. Observation in the three-compartment sink on September 2, 2025, at 10:09 AM, revealed dirty pans in the wash section, and the sanitizer sink filled with water and sanitizing solution. Employee 3 (FSD- Food Service Director) tested the sanitizer concentration with testing strips. The surveyor checked the expiration date on the strip container used to test the concentration of the sanitizer, and it revealed an expiration date of May 1, 2024. Interview with Employee 3 on September 2, 2025, at 10:14 AM, revealed he would expect labeling and dating per facility policy, and he would be reaching out to their supplier for new test strips. Return visit to the main kitchen on September 3, 2025, at 11:37 AM, revealed the blank temperature log from July 2025 remained on the wall overtop of the three-compartment sink. Interview with Employee 3 on September 3, 2025, at 11:38 AM, revealed the concentration of the sanitizer solution did not get logged from the morning of September 2, 2025, and that there are no logged sanitizer solution concentration measures since July 2025. Interview with the Nursing Home Administrator on September 3, 2025, at 1:20 PM, revealed it is his expectation that food items are labeled and dated per facility policy, and kitchen equipment is utilized in accordance with professional standards. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Based on an observations, facility policy review, record review, and staff interviews, the facility failed to implement infection control policies regarding Enhanced Barrier Precautions for eight of 19 Residents reviewed (Residents 1, 2, 6, 7, 10, 11, 12, and 13). Findings include: Review of facility policy, Enhanced Barrier Precautions, dated July 22, 2025, read, in part, indications for use include chronic wounds and/or indwelling medical devices such as central lines regardless of MDRO (multidrug-resistant organism) status. Review of Resident 1's clinical record revealed diagnoses that included gastrostomy status (a surgical procedure that involves creating an opening in the stomach through the abdominal wall, with the placement of a feeding tube) and cerebral palsy (a neurological disorder that affects body movement and muscle coordination, typically caused by abnormal brain development or damage to the brain). Observations outside of Resident 1's room on September 2, 2025, between 9:40 AM and 12:26 PM, failed to reveal any signage indicating that Resident 1 was on enhanced barrier precautions (EBP). Observations outside of Resident 1's room on September 3, 2025, between 9:30 AM and 11:52 AM, failed to reveal any signage indicating that Resident 1 was on EBP. Review of Resident 1's physician orders failed to reveal an order to follow EBP when caring for Resident 1. Review of Resident 1's comprehensive care plan failed to reveal any mention of the need to follow EBP when caring for Resident 1. Review of Resident 2's clinical record revealed diagnoses that included hypertension (elevated/high blood pressure) and type II diabetes mellitus (decreased ability of the body to utilize insulin for the transport of glucose from the blood stream into the cells for nourishment). Review of Resident 2's clinical record revealed that Resident 2 had a Percutaneous Endoscopic Gastrostomy tube (PEG tube - feeding tube surgically inserted into the stomach that extends through the abdomen for long term nutrition and hydration needs) and a foley catheter (tube inserted into the bladder through the urethra to facilitate the removal of urine from the bladder). During multiple observations of Resident 2's room on September 2, 2025 through September 4, 2025, failed to reveal any signage indicating that Resident 2 was on EBP. Review of Resident 2's physician orders revealed no order for EBP for Resident 2. Review of Resident 2's comprehensive plan of care revealed that EBP was not included in Resident 2's comprehensive plan of care. During observation on September 4, 2025, at approximately 9:28 AM, two Nurse Aides (Employee 4 and Employee 6) were observed in Resident 2's room. Resident 2 was observed in a wheelchair. Employee 6 was observed holding a bag of what appeared to be soiled linens. It was also observed that there was a lift in the room. When Employee 4 and Employee 6 exited Resident 2's room, Employee 4 and Employee 6 confirmed they were providing incontinence care and transferred resident to the wheelchair. Employee 4 and Employee 6 confirmed that they did not wear gowns during the care provided. Review of a resident list identifying residents on EBP, provided by the facility's infection preventionist on September 4, 2025, at approximately 10:00 AM, revealed the facility had not placed Resident 2 on EBP. Review of Resident 6's clinical record revealed diagnoses that included dysphagia (difficulty swallowing). Observation of Resident 6's room on September 2nd, 2025, at 12:20 AM, and September 4th, 2025, at 10:00 AM, revealed there was no identification for the need for EBP. Review of Resident 6's care plan revealed a focus area for PEG (percutaneous endoscopic gastrostomy - a thin, flexible tube inserted through the skin of the abdomen and into the stomach) tube placement related to dysphagia. Further review of the care plan failed to reveal any mention of the need to follow EBP when caring for Resident 6. Review of Resident 6's physician orders included Glucerna 1.5 via J tube (jejunostomy tube- a surgically place tube that delivers nutrients and medication directly into the jejunum, the second part of the small intestine) 65 ml/hr until 780 ml has been infused every day via a pump, started June 9, 2023; cleanse PEG tube with normal saline solution and apply drain sponge as needed every day and evening shift, started March 4, 2025; and J/G tube medically necessary due to dysphagia, ordered February 19, 2021. Further review of the physician orders failed to reveal an order for the need to follow EBP when caring for Resident 6. Review of Resident 7's clinical record revealed diagnoses that included neurogenic bladder (a condition that occurs when the relationship between the nervous system and the bladder function is disrupted) and urinary tract infection (an infection of the urinary tract). Observation of Resident 7 on September 2, 2025, at 10:35 AM, revealed that Resident 7 had a suprapubic catheter (a flexible tube inserted into the bladder through the abdomen to drain urine). Further observation outside of Resident 7's room failed to reveal any signage indicating that Resident 7 was on EBP. Review of Resident 7's care plan revealed a care plan with a focus area of, Presence of Suprapubic Catheter. Further review of the care plan failed to reveal any mention of the need to follow ERP</p> | | |