

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: 396093	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER Richfield Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 631 Main Street Richfield, PA 17086	
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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on clinical record review, and staff interview, it was determined that the facility failed to provide recommended pneumococcal immunizations for three of five residents reviewed for immunizations (Residents 1, 9, 12). Findings include: Clinical record review revealed the facility admitted Resident 1 on November 2, 2023. Documentation in Resident 1's clinical record revealed she received two pneumococcal vaccines prior to her admission (Pneumovax 23 and Prevnar 13). Review of Resident 1's pneumococcal consent dated November 2, 2023, revealed Resident 1's representative wanted the facility to administer Resident 1 the pneumococcal vaccine. Clinical record review revealed the facility admitted Resident 9 on April 17, 2023. Documentation in Resident 9's clinical record revealed she received two pneumococcal vaccines prior to her admission (Pneumovax 23 and Prevnar 13). Review of Resident 9's pneumococcal consent dated April 18, 2023, revealed Resident 9's representative wanted the facility to administer Resident 9 the pneumococcal vaccine. Clinical record review revealed the facility admitted Resident 12 on October 20, 2023. Documentation in Resident 12's clinical record revealed she received two pneumococcal vaccines prior to her admission (Pneumovax 23 and Prevnar 13). Review of Resident 12's pneumococcal consent dated October 21, 2023, revealed Resident 12's representative wanted the facility to administer Resident 12 the pneumococcal vaccine. According to the CDC (Centers for Disease Control and Prevention) guidance entitled Pneumococcal Vaccine Timing for Adults dated October 2024, Residents 1, 9, and 12 pneumococcal vaccinations would not be completed until they received PCV20 or PCV21 pneumococcal vaccines, five years after the last pneumococcal vaccine doses. There was no documented evidence to indicate that the facility offered Residents 1, 9, and 12 an updated pneumococcal vaccination. Interview with Employee 1, infection control preventionist, on January 22, 2026, at 10:30 AM confirmed the above findings for Residents 1, 9, and 12. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **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 establish clear end of life directives for one of four residents reviewed (Resident 4). Findings include: Clinical record review for Resident 4 revealed an active physician's order dated [DATE], that indicated the resident was a DNR (do not resuscitate, do not attempt CPR (cardiopulmonary resuscitation) when the person has no pulse and is not breathing). Clinical record review for Resident 4 revealed a social services note dated [DATE], at 2:17 PM that noted the resident's code status was changed to DNR with comfort measures. Review of Resident 4's current plan of care last revised on [DATE], revealed the resident expressed the desire to be a DNR. A review of the Resident 4's paper clinical record kept at the nurse's station on [DATE], at 12:45 PM revealed a POLST (Pennsylvania Orders for Life-Sustaining Treatment, a form directing medical staff to complete life-sustaining treatment or allow a natural death) for the resident dated [DATE], which indicated in the event the resident has no pulse and is not breathing to perform CPR. The above information regarding Resident 4's wishes to be a DNR not matching the resident's POLST was concurrently reviewed with the Nursing Home Administrator on [DATE], at 12:45 PM. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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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. Based on clinical record review and resident and staff interview, it was determined that the facility failed to implement a comprehensive person-centered care plan regarding constipation for one out of 18 residents reviewed (Resident 31). Findings include: During an interview with Resident 31 on January 20, 2026, at 2:03 PM, the resident stated he was having some constipation for the last day or two. Clinical record review for Resident 31 revealed that the resident was diagnosed with constipation on December 12, 2025, upon admission. Review of Resident 31's active physician's orders revealed the resident was prescribed routine Senna S Oral (a laxative medication that acts to soften stool and stimulate the bowels to produce bowel movements). Further review revealed that the resident was also prescribed a three-step bowel protocol (a series of medical interventions that are initiated sequentially when the resident does not have a bowel movement independently, and the previous step was ineffectual). Review of Resident 31's current comprehensive plan of care (a summary of a resident's personal health, nursing, and psychological well-being needs and how they can be met) revealed no evidence Resident's 31's constipation diagnosis was addressed on the resident's plan of care. An interview with the Nursing Home Administrator and the Director of Nursing on January 22, 2026, at 12:40 PM, it was confirmed that facility staff did not address the resident's medical diagnosis of constipation in the resident's comprehensive plan of care. 28 Pa. Code 211.10. (a)(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on clinical record review and resident and staff interview, it was determined that the facility failed to promote resident involvement with care plan development for one of one resident reviewed (Resident 3). Findings include: In an interview with Resident 3 on January 20, 2026, at 1:25 PM, the resident stated she does not remember being invited to care plan meetings. Clinical record review for Resident 3 did not reveal any evidence that the resident was invited, attended, declined to attend, or was involved in her interdisciplinary care plan meetings in the last twelve months. During an interview with Employee 4, social worker, on January 21, 2026, at 2:37 PM, Employee 4 stated that she does not document when a resident is invited to their care plan meeting, or if they are present for the meeting. Employee 4 indicated there was no evidence to indicate Resident 3 was invited, attended, declined to attend, or involved in her care plan meeting over the prior twelve months. The Nursing Home Administrator and the Director of Nursing were made aware of the above findings on January 22, 2026, at 9:00 AM. 28 Pa. Code 211.12(d)(3) Nursing services		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on clinical record review and staff interview, it was determined that the facility failed to assess and implement individualized interventions to promote bowel and bladder continence for one of two residents reviewed for incontinence (Resident 1). Findings include: Observation of Resident 1 on October 20, 2026, at 10:54 AM revealed Resident 1 was seated in a chair in the hallway. Resident 1 stated to the surveyor that she was having a bowel movement and needed staff assistance. Clinical record review for Resident 1 revealed an annual MDS (Minimum Data Set, an assessment completed at specific intervals to determine care needs) dated August 9, 2025, in which facility staff assessed Resident 1 as continent of her bowel, and occasionally incontinent of her bladder. Further review of Resident 1's clinical record revealed an MDS assessment completed on October 31, 2025, noting staff assessed Resident 1 as now frequently incontinent of bowel and bladder. Further review of the MDS revealed Resident 1 is dependent on staff for toilet transfers. Further review of Resident 1's clinical record revealed the last assessment of Resident 1's bowel and bladder status was on November 11, 2025, and it did not address Resident 1's decline in her bowel and bladder continence or implement interventions to address the declines. The facility failed to assess and implement individualized interventions to promote Resident 1's bowel and bladder continence. The findings were reviewed with the Director of Nursing on January 22, 2026, at 11:57 AM, and she was unable to provide any further documentation addressing Resident 1's bowel and bladder decline. 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to obtain professional dental services for one of two residents reviewed for dental concerns (Resident 12). Findings include: Observation of Resident 12 on January 20, 2026, at 12:01 PM revealed Resident 12 was sitting in her personal chair in her room. Resident 12 was unable to answer any questions related to her dental history due to her current cognitive status. Resident 12 appeared to have her own teeth. Clinical record review the facility admitted Resident 12 on October 20, 2023. The surveyor requested evidence of professional dental care services provided for Resident 12 in the past year during an interview with the Director of Nursing and the Nursing Home Administrator on January 21, 2026, at 11:30 AM. Interview with the Director of Nursing on January 22, 2026, at 9:22 AM confirmed that Resident 12 consented to services from the facility's contracted provider for dental services on March 18, 2024. Resident 12 became eligible for Medicaid-provided services on September 25, 2025. The facility had no evidence that the contracted provider provided services since Resident 12's admission to the facility. 483.55 (b)(1)(2) Dental Services Previously cited 2/6/2528 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on clinical record review and staff interview, it was determined that the facility failed to ensure complete and accurate clinical documentation for one of 12 residents reviewed (Resident 5). Findings include: Clinical record review for Resident 5 revealed a diagnosis list that included essential hypertension (high blood pressure). Current physician orders for Resident 5 revealed an order dated September 11, 2025, at 8:00 PM for Metoprolol Tartrate (a medication that is used to treat high blood pressure and/or heartrate) oral tablet 25 milligrams (mg) give one tablet by mouth two times a day related to essential (primary) hypertension. The order indicated a blood pressure and heartrate hold: hold if heartrate less than 60; systolic blood pressure (SBP, the top number of a blood pressure reading where the heart contracts) less than 100. A review of the Medication Administration Record (MAR) for January 2026 for Resident 5 revealed that facility staff were documenting the blood pressure, however the heartrate was not being documented. A review of the vital signs section of the electronic health record (EHR) for Resident 5 revealed the only documented heartrate / pulse for January was on January 9, 2026, at 10:09 AM; January 21, 2026, at 6:27 AM, and January 21, 2026, at 7:24 PM. There was no documented pulse to coincide with each administration of the resident's Metoprolol. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on January 21, 2026, at 11:30 AM. Further clinical record review for Resident 5 revealed an order revision dated January 21, 2026, for Resident 5 that now included an area on the MAR to document the resident's heartrate. 28 Pa. Code 211.5(i) Medical records 28 Pa. Code 211.12(d)(1)(3)(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 review of select facility policies, observation, clinical record review, and staff interview, it was determined that the facility failed to provide the highest practicable care regarding enhanced barrier precautions for two of 12 residents reviewed (Residents 25 and 31). Findings include: Review of the facility's current policy entitled, Enhanced Barrier Precautions (EBP), revealed it is the facility's purpose to reduce the transmission of multi-drug-resistant organisms (MDROs) through the appropriate and targeted use of enhanced barrier precautions while maintaining residents' quality of life. Further review of the policy revealed that EBP are used when contact precautions do not otherwise apply and involve the targeted use of gowns and gloves during high-contact resident care activities. The policy further noted that the presence of an indwelling medical device alone, including a foley catheter, does not automatically require enhanced barrier precautions. Clinical record review for Resident 25 revealed a diagnosis list that included benign prostatic hyperplasia with lower urinary tract symptoms (an enlarged prostate which may impede urine flow) and obstructive and reflux uropathy (blockage in the urinary tract which impacts the flow of urine). Current physician orders for Resident 25 included a foley catheter (indwelling medical tubing used to drain urine from the bladder) and associated catheter care. The current care plan for Resident 25 included a plan of care initiated on November 13, 2025, for use of an indwelling urinary catheter. Observation of Resident 25 on January 20, 2026, at 11:40 AM revealed that the resident was seated in a recliner in the common area living room of the facility. The resident had a foley drainage bag attached to the recliner. Concurrent observation of Resident 25's room revealed no evidence that the resident was on EBP due to having a foley catheter. There was no sign at the entrance to Resident 25's room indicating EBP precautions were in place, no personal protective equipment (PPE) in the room or at the doorway to don (put on), or any sign placed anywhere in the room that indicated staff or visitors were to see the nurse prior to care. In an interview with Employee 2, licensed practical nurse, on January 20, 2026, at 2:29 PM Employee 2 stated there were no residents in the hallway where Resident 25 resided that were currently on isolation or EBP. The above information for Resident 25 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on January 21, 2026, at 11:30 AM and the policy for isolation and enhanced barrier precautions was requested by the surveyor. Observation of Resident 31's room on January 20, 2026, at 11:55 AM revealed no EBP sign on or near the resident's door. Interview and observation of Resident 31 on January 20, 2026, at 2:00 PM, revealed the resident has a foley catheter which he has had since admission to the facility on December 12, 2025. The above information regarding Resident 31 was reviewed with the Director of Nursing on January 21, 2026, at 11:10 AM. The Director of Nursing indicated the facility only placed residents diagnosed with an MDRO on EBP and failed to implement the precautions for the above residents with an indwelling medical device. 483.80 Infection Prevention and Control Previously cited deficiency 2/6/25 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		