

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396150	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2025
NAME OF PROVIDER OR SUPPLIER Advanced Health Care of Hanover		STREET ADDRESS, CITY, STATE, ZIP CODE 3370 High Pointe Boulevard Bethlehem, PA 18017	

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)
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**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 notify the resident and the resident's representative of the bed hold policy and transfer, including the reasons for the transfer and Ombudsman information, in writing upon transfer from the facility, for two of two sampled residents who were transferred to the hospital. (Residents 2, 41)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 2 was transferred and admitted to the hospital on [DATE], after a change in condition. There was no documentation to support that the resident or the resident's responsible party or legal representative was provided written information regarding the bed hold policy or the transfer to the hospital.</p> <p>Clinical record review revealed that Resident 41 was transferred and admitted to the hospital on [DATE], after a change in condition. There was no documentation to support that the resident or the resident's responsible party or legal representative was provided written information regarding the bed hold policy or the transfer to the hospital.</p> <p>In an interview on June 18, 2025, at 1:30 p.m., the Administrator confirmed there was no documentation to support that the above notices were sent.</p>

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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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**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 complete and electronically transmit encoded Minimum Data Set (MDS) assessment data to the Centers for Medicare and Medicaid Services (CMS) within 14 days for one of 14 sampled residents. (Resident 13)</p> <p>Findings include:</p> <p>Clinical record review on June 17, 2025, revealed that Resident 13 had a Quarterly MDS assessment dated [DATE], that was still in progress and had not yet been completed and transmitted to CMS as per the time requirements.</p> <p>In an interview on June 18, 2025, at 9:50 a.m., the Director of Nursing confirmed that the MDS assessment had not been completed and transmitted to CMS within the required time frame.</p> <p>CFR 483.20(f)(3) Transmittal Requirements</p> <p>Previously cited 7/3/24.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**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 develop a comprehensive care plan to meet each resident's needs as identified in the comprehensive assessment for three of 14 sampled residents. (Residents 12, 20, 44)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 12 was admitted to the facility on [DATE], and had diagnoses that included diabetes, lower limb cellulitis, and gastro-esophageal reflux disease. The Minimum Data Set (MDS) Care Area Assessment (CAA) summary dated May 25, 2025, noted that the resident's vision, activities of daily living, dental care, and nutrition were to be addressed in the care plan. There was no documented evidence that interventions to address those areas were included on Resident 12's care plan.</p> <p>Clinical record review revealed that Resident 20 was admitted to the facility on [DATE], and had diagnoses that included hearing loss, high cholesterol, and a recent total knee replacement. The MDS CAA summary dated June 4, 2025, noted that the resident's communication, nutrition, and activities of daily living were to be addressed in the care plan. There was no documented evidence that interventions to address those areas were included in Resident 20's care plan.</p> <p>Clinical record review revealed that Resident 44 was admitted to the facility on [DATE], and had diagnoses that included depression. The MDS CAA summary dated March 20, 2025, noted that the resident's psychotropic drug use was to be addressed in the care plan. Review of the medication administration record revealed the resident received an antidepressant (trazodone) March through June 2025. There was no documented evidence that interventions to address Resident 44's psychotropic drug use were included in the care plan.</p> <p>In interviews on June 18, 2025, at 9:50 a.m. and 1:47 p.m., the Director of Nursing confirmed the identified care areas were not addressed in the care plans.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, resident interview, and staff interview, it was determined that the facility failed to provide services to maintain adequate grooming and hygiene for one of 14 sampled residents who required assistance with activities of daily living (ADLs). (Resident 23)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 23 had diagnoses that included heart failure and metabolic encephalopathy (a change in brain function). The Minimum Data Set (MDS) assessment dated [DATE], revealed that Resident 23 was dependent on staff for personal hygiene and bathing. Review of the care plan revealed that the resident required assistance from staff for ADLs, including grooming, personal hygiene and bathing. On June 16, 2025, at 10:30 a.m., the resident was observed in bed. His fingernails were long and dirty. On June 17, at 11:40 a.m., the resident was observed with his nails in the same condition. In an interview at that time, Resident 23 stated he would like his nails to be trimmed and cleaned, and staff had not offered to do them. There was no documented evidence that staff offered to assist Resident 23 with trimming and cleaning his nails.</p> <p>In an interview on June 17, 2025, at 1:40 p.m., the Director of Nursing confirmed that nail care was to be done when nursing staff was providing routine care and as needed.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to implement physicians' orders for four of 14 sampled residents. (Residents 12, 20, 23, 208)</p> <p>Findings include:</p> <p>Review of the policy entitled, Medication Administration, last reviewed January 8, 2025, revealed that staff were to administer medications in accordance with the written orders of the physician and ensure vital signs were performed with appropriate medications. In an interview on June 18, 2025, at 2:30 p.m., with the Director of Nursing stated that any vital signs obtained for parameters per the physicians' orders were to be entered into the Medication Administration Record (MAR) as indicated.</p> <p>Clinical record review revealed that Resident 12 was admitted to the facility on [DATE], and had diagnoses that included heart failure and kidney disease. On May 20, 2025, the physician ordered for staff to weigh the resident daily and to notify the physician of weight gain greater than five pounds in a week or three pounds in one day. Review of Resident 12's June 2025 MAR revealed no evidence that staff weighed Resident 12 on June 1, 2, 3, 6, 8, 10, 12, 13, 14, 15, 16, and 17, 2025.</p> <p>Clinical record review revealed that Resident 20 was admitted to the facility on [DATE], and had diagnoses that included diabetes, heart failure, and kidney failure. On May 30, 2025, the physician ordered staff to weigh the resident daily and to notify the physician of weight gain greater than five pounds in a week or three pounds in one day. Review of Resident 20's June 2025 MAR revealed no evidence that staff weighed Resident 20 on June 2, 8, 9, 10, 11, 12, 13, 14, 15, 16, and 17, 2025.</p> <p>Clinical record review revealed that Resident 23 had diagnoses that included high blood pressure. On May 31, 2025, the physician ordered staff to administer a blood pressure medication (metoprolol tartrate) two times a day. Staff were not to administer the medication if the resident's heart rate (the number of times a heart beats in one minute) was less than 55. Review of Resident 23's June 2025 MAR revealed that staff administered the medication on June 2, 6, 8, 13, and 16, 2025, and there was a lack of evidence to support that staff assessed the heart rate prior to medication administration on those dates.</p> <p>Clinical record review revealed that Resident 208 was admitted to the facility on [DATE], and had diagnoses that included heart failure, high blood pressure, and kidney disease. On June 5, 2025, the physician ordered staff to weigh the resident daily and to notify the physician of weight gain greater than five pounds in a week or three pounds in one day. Review of Resident 208's June 2025 MAR revealed no evidence that staff weighed Resident 208 on June 5, 6, 7, 8, 11, 12, 14, 15, 16, and 17, 2025.</p> <p>In interviews on June 18, 2025, at 1:42 p.m. and 2:30 p.m., the Director of Nursing confirmed there was no documented evidence that the above noted daily weights or heart rates were obtained per the physicians' orders.</p> <p>CFR 483.25 Quality of Care</p> <p>(continued on next page)</p>		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Previously cited 7/3/24. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, resident interview, and staff interview, it was determined that the facility failed to ensure residents were served preferred items on their meal trays for one of 14 sampled residents. (Resident 208)</p> <p>Findings include:</p> <p>Review of the facility dining services menu for June 17, 2025, revealed that the breakfast meal included fruit, pancakes with syrup, hot or cold cereal, sausage, milk, and choice of juice.</p> <p>Clinical record review revealed that Resident 208 had diagnoses that included chronic kidney disease and heart failure. The Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident had no cognitive impairment. On June 17, 2025, at 9:17 a.m., the resident was observed with her breakfast meal that consisted of eggs on a tortilla, fruit, hot tea, and milk. Review of the resident's menu selections that were submitted to the kitchen revealed that she requested the pancake and sausage for her breakfast meal. The resident was observed having difficulty eating her breakfast and stated that she would have preferred the pancakes and sausage.</p> <p>In an interview on June 18, 2025, at 9:41 a.m., the Administrator stated that the dietary department was expected to follow the residents' selections identified on the weekly menu selection form.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b) Management.</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p>Based on clinical record review and observation, it was determined that the facility failed to ensure that adaptive equipment was provided to one of 14 sampled residents. (Resident 208)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 208 had diagnoses that included a recent upper arm fracture and osteoarthritis to the right dominant hand. Review of a nurse's note dated June 15, 2025, revealed that the resident had vision problems. The care plan indicated that the resident had vision problems and required assistance with activities of daily living, including dietary tasks. Occupational therapy documentation dated June 8 and 9, 2025, indicated the resident required an inner lip plate and built-up utensils for every meal, visual cues when eating, and for staff to cut up her food.</p> <p>Observations on June 16, 2025, from 1:05 p.m. to 1:25 p.m., revealed Resident 208 was eating her lunch in her room. She did not have an inner lip plate on her tray and was observed having difficulty picking up and managing her cheeseburger with her right hand.</p> <p>On June 17, 2025, from 9:00 a.m. to 9:15 a.m., Resident 208 was observed eating breakfast in her room. The resident's tray did not have an inner lip plate, contained weighted utensils (not built up utensils), and the food was not cut into pieces. The resident was observed having difficulty cutting the eggs and could not cut the tortilla. On June 17, 2025, from 1:15 p.m. to 1:30 p.m., Resident 208 was observed eating her lunch in her room. The resident did not have her inner lip plate on the meal tray and was observed struggling to pick up her food with the utensils. The lunch meal consisted of chicken, cauliflower, and rice. The chicken was not cut into pieces.</p> <p>In an interview on June 18, 2025, at 9:41 a.m., the NHA confirmed the adaptive equipment should have been in place for Resident 208.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</p>		