STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395047	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HERITAGE POINTE REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **070102**	**400 SOUTH MAIN STREET DOYLESTOWN, PA 18901**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification survey, State Licensure survey, and a Civil Rights Compliance survey completed on December 5, 2024, it was determined that Heritage Pointe Rehabilitation and Healthcare Center, was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0656 SS=D		F 0656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0656 SS=D	Continued from page 1 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	A comprehensive care plan has been developed for Resident 10 to address individual resident needs as identified in a comprehensive assessment. A comprehensive care plan will be developed for any identified needs at the time of an MDS. RNAC will review CAA report with Nursing. RNACs & Nursing will be educated on the CAA & care plan process. Care Plan audit will be conducted based on the CAA reports to ensure all identified areas have been care planed x 4weeks. Audit Findings to be reported to QAPI Committee	Completion Date: **01/07/2025** Status: **APPROVED** Date: **12/17/2024**

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F 0656 SS=D	Continued from page 2 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656		

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F 0656 SS=D	Continued from page 3 Based on clinical record review, observation, and staff interview, it was determined that the facility failed to develop a comprehensive care plan that addressed individual resident needs as identified in the comprehensive assessment for one of 24 sampled residents. (Resident 10) Findings include: Clinical record review revealed that Resident 10 was admitted to the facility on November 14, 2024, and had diagnoses that included malnutrition, colitis (inflammation of the colon), and dysphagia (difficulty swallowing). The Minimum Data Set Care Area Assessment summary dated November 18, 2024, noted that the resident's dehydration and fluid maintenance and dental care were to be addressed in the care plan. There was no evidence that interventions to address Resident's 10's dehydration and fluid maintenance or dental care included in the current care plan. In an interview on December 5, 2024, at 11:32	F 0656		

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F 0656 SS=D	Continued from page 4 a.m., the Director of Nursing confirmed there was no documented evidence that the care areas were addressed in the care plan. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0656		
F 0812 SS=F		F 0812		

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F 0812 SS=F	Continued from page 5 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	Immediate corrective action taken: 1. a. Washed and sanitized lids from the cereal dispenser. b. Debris on the floor of the dry storage room was immediately swept and mopped. c. Fridge #3 & 5 and Freezer #7 was cleared of debris inside the coolers. d. Uncovered box of green beans in the #6 reach-in freezer was immediately resealed and all debris was wiped down. e. Dry white liquid in the #5 reach-in refrigerator was immediately wiped down. f. Two opened containers of yogurt in the #4 reach-in refrigerator that had dripped on its side were immediately whipped down. All debris on the bottom of the refrigerator was whipped down. g. Open bag of carrots in the #2 refrigerator with no date were discarded immediately along with a bowl of coleslaw and a pan of green beans with expired dates. The open jar of applesauce was immediately dated with a 7 day expiration label. Leftover pancakes and bread were	Completion Date: **01/07/2025** Status: **APPROVED** Date: **12/19/2024**

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F 0812 SS=F	Continued from page 6	F 0812	immediately discarded. All debris was wiped off from the bottom of the refrigerator. h. A metal lid and two containers under the storage shelving were immediately picked up, washed and sanitized. i. The microwave with debris was immediately washed and sanitized. j. All personnel with facial hair were instructed to wear a beard guard. 2. This citation has the potential to effect any resident. 3. Dietary staff will complete the following educations prior to returning to work: Cleaning and Sanitizing In-service; Cleaning Procedures In-services; Cold food storage Policy; Environment Policy and Procedure; Receiving and Storage of Food In-service. Audit: 1. FSD (or designee) will complete Sanitation Audit monitoring log 5 days a week, for 30 days. Monitor and QAPI: 1. The Sanitation audit findings will be reported to QAPI Committee.	

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F 0812 SS=F	Continued from page 7 Based on policy review, staff interview, and observation, it was determined that the facility failed to properly store food and maintain sanitary conditions in the dietary department. Findings include: Review of the facility's policy entitled, "Labeling and Dating," dated October 29, 2024, revealed that leftovers were to be labelled with the date that they were prepared and the "use-by" date. Prepared foods were to be discarded after seven days. Review of the facility's policy entitled, "Staff Attire," dated October 29, 2024, revealed that all staff with facial hair were to have it properly restrained. Observations during the tour of the dietary department on December 3, 2024, at 10:12 a.m., revealed the following: In dry storage, there was food and paper debris on the floor under two sets of shelves storing food	F 0812		

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F 0812 SS=F	Continued from page 8 items. There was flour on the floor below the bulk container of flour. There were two bulk containers of cereal that had food debris and/or a dried liquid ring on the lids. In reach-in freezer #7, there was an accumulation of a frozen liquid on the bottom of the freezer. In reach-in freezer #6, there was an opened, uncovered box of green beans. There was a layer of food debris along the inside bottom of the freezer. In reach-in cooler #5, there was dried white liquid on the floor under the milk storage. In reach-in cooler #4, there were two opened containers with yogurt that had dripped onto the containers and the shelf below. In reach-in coolers #3 and #5, there was a layer of food debris along the bottom of the inside of the coolers. In reach-in cooler #2, there was an opened bag of shredded carrots that was not dated. There was a large bowl coleslaw labeled "use-by November 30" and an opened container of bulk applesauce that	F 0812		

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F 0812 SS=F	Continued from page 9 was dated November 22, 2024. There was a container with leftover pancakes stored directly on top of bread that was not dated. There was a layer of food debris on the bottom of the cooler. In reach-in cooler #1, there was a large container of cooked green beans that was not dated. There were two containers and one metal lid on the floor under a storage rack of pans and containers. Inside the microwave, there were multiple areas of dried food debris. In an interview on December 3, 2024, at 11:10 a.m., the District Manager of the dietary department (DM 1) confirmed the previously mentioned foods should have been dated and expired items removed. Observation during of the lunch meal service tray line on December 4, 2024, from 12:25 p.m. to 12:43 p.m., revealed Dietary Employee 1 (DE 1) and Dietary Employee 2 (DE 2) were both observed to have facial hair of a full beard and	F 0812		

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F 0812 SS=F	Continued from page 10 mustache that were not covered. In an interview on December 4, 2024, at 12:50 p.m., the DM 1 confirmed that DE 1 and DE 2 should have been wearing beard guards during meal tray line. 28 Pa. Code 201.14(a) Responsibility of licensee.	F 0812		
F 0814 SS=C		F 0814		

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F 0814 SS=C	Continued from page 11 483.60(i)(4) Dispose Garbage and Refuse Properly §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by:	F 0814	1. Swept and discarded all debris around the dumpster. Steps to prevent reoccurrence: 1. dietary staff will complete education: review of the garbage and refuse policy. Audit: 1. FSD (or designee) will complete dumpster area monitoring log for 30 days. 2 Sanitation audit findings will be reported to QAPI Committee.	Completion Date: **01/07/2025** Status: **APPROVED** Date: **12/18/2024**

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F 0814 SS=C	Continued from page 12 Based on observation, it was determined that the facility failed to dispose of trash and refuse properly. Findings include: Observation of the trash compactor area on December 3, 2024, at 10:30 a.m., revealed various items on the ground next to the trash compactor, including a full bag containing three used briefs, used gloves, used gauze, and several pieces of crushed plastic items. There was a plastic bag containing garbage items that was sticking out from below the trash compactor. 28 Pa Code 201.18(b)(3) Management.	F 0814		

Certified End Page

HERITAGE POINTE REHABILITATION AND HEALTHCARE CENTER

STATE LICENSE NUMBER: 070102

SURVEY EXIT DATE: 12/05/2024

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY