

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395277	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: HARBORVIEW REHABILITATION AND CARE CENTER AT DOYLESTOWN	STREET ADDRESS, CITY, STATE, ZIP CODE: 432 MAPLE AVENUE DOYLESTOWN, PA 18901
STATE LICENSE NUMBER: 040502	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	F 0000		
F 0804 SS=D	Based on an Abbreviated survey in response to three complaints completed on February 5, 2025, it was determined that Harborview Rehabilitation and Care Center at Doylestown, 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 0804		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395277	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025
NAME OF PROVIDER OR SUPPLIER: HARBORVIEW REHABILITATION AND CARE CENTER AT DOYLESTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE: 432 MAPLE AVENUE DOYLESTOWN, PA 18901		
STATE LICENSE NUMBER: 040502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 0804 SS=D	Continued from page 1 483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by:	F 0804	1. Nursing staff will be re-educated on passing meal trays timely to ensure meals are served at acceptable temperatures. Dietary staff will be educated on preparing food in order to maintain proper service temperatures. 2. Facility Food Service Director/Dietician will hold routine food committee meetings with residents. NHA will review food committee meeting minutes to ensure follow up to residents' concerns. 3. NHA/Designee will conduct test tray audits of resident meals. Audit will be conducted 3 x week for 2 weeks, then weekly x 4. All results will be reported to the QAPI Committee.	Completion Date: 03/07/2025 Status: APPROVED Date: 02/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395277	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025	
NAME OF PROVIDER OR SUPPLIER: HARBORVIEW REHABILITATION AND CARE CENTER AT DOYLESTOWN STATE LICENSE NUMBER: 040502		STREET ADDRESS, CITY, STATE, ZIP CODE: 432 MAPLE AVENUE DOYLESTOWN, PA 18901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 0804 SS=D	Continued from page 2 Based on observation, resident interview, staff interview, and results of a test tray audit, it was determined that the facility failed to ensure that residents were served food that was palatable and at acceptable temperatures on one of three nursing units (First Floor) for five of six sampled residents. (Residents 1, 2, 4, 5, 6) Findings include: Observation on February 5, 2025, at 11:46 a.m., revealed that the food cart for the First Floor nursing unit left the kitchen at 11:46 a.m. and arrived on the nursing unit at 11:47 a.m. The cart sat in the dining room until 11:59 a.m., when staff began to distribute the food trays to residents. The last tray was served at 12:05 p.m., 18 minutes after the food cart had arrived on the nursing unit. At that time, the temperatures of the food on the tray were as follow: The main entree of penne pasta and Bolognese	F 0804		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395277	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025	
NAME OF PROVIDER OR SUPPLIER: HARBORVIEW REHABILITATION AND CARE CENTER AT DOYLESTOWN STATE LICENSE NUMBER: 040502		STREET ADDRESS, CITY, STATE, ZIP CODE: 432 MAPLE AVENUE DOYLESTOWN, PA 18901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 0804 SS=D	Continued from page 3 sauce was 122 degrees Fahrenheit. The chef's blend vegetables that included broccoli and carrots was 100 degrees Fahrenheit. The main entree and the vegetables were cool to taste and were not palatable. In an interview, on February 5, 2025, at 11:35 a.m., the Director of Dietary stated that hot food was to be served at 130 degrees Fahrenheit at the point of service to residents and that trays were to be distributed to residents from the food cart within 10 minutes of arrival to the nursing unit. Clinical record review revealed that Residents 1, 2, 4, 5, and 6 were alert and oriented and able to make their needs known to staff. In an interview on February 5, 2025, at 12:05 p.m., Residents 4 and 6 stated that the lunch today was served cold and was not palatable.	F 0804		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395277	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025
NAME OF PROVIDER OR SUPPLIER: HARBORVIEW REHABILITATION AND CARE CENTER AT DOYLESTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE: 432 MAPLE AVENUE DOYLESTOWN, PA 18901		
STATE LICENSE NUMBER: 040502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 0804 SS=D	Continued from page 4 In an interview on February 5, 2025, at 12:10 p.m., Resident 5 stated that the food "was not good" and was often served cold. In an interview on February 5, 2025, at 12:15 p.m., Resident 1 stated that the food, including today, was often served cold and did not always taste good. In an interview on February 5, 2025, at 12:20 p.m., Resident 2 stated that the food, including today, was often served cold and was not palatable. Observation revealed that Resident 2 did not eat much of her meal. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(3) Management.	F 0804		
F 0919 SS=D		F 0919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395277	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025
NAME OF PROVIDER OR SUPPLIER: HARBORVIEW REHABILITATION AND CARE CENTER AT DOYLESTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE: 432 MAPLE AVENUE DOYLESTOWN, PA 18901		
STATE LICENSE NUMBER: 040502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 0919 SS=D	Continued from page 5 483.90(g)(1)(2) Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by:	F 0919	1. Facility issued hand bells to Residents 1, 2, 5, and 6. 2. Facility will conduct a whole house audit on the call bell system and provide additional hand bell or fix the issues. 3. Facility has contacted an electrical company to assess repairs needed for the call bell system. Once the facility receives the service report, it will make a plan to address areas of the system that are in need of parts for repairs or replacement. Assessment was completed and awaiting to locate and to order necessary parts to repair or replace unsure whether parts will be found by POC date. 4. Nursing Staff, IDT, and maintenance team will be re-educated on the need to provide a working call bell system. Re-education will include steps to take in the event a call bell is determined not to work. 5. NHA/Designee will conduct audits of the call bell system to ensure the system is maintained and functioning properly. Audits will be	Completion Date: 03/07/2025 Status: APPROVED Date: 03/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395277	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025
NAME OF PROVIDER OR SUPPLIER: HARBORVIEW REHABILITATION AND CARE CENTER AT DOYLESTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE: 432 MAPLE AVENUE DOYLESTOWN, PA 18901		
STATE LICENSE NUMBER: 040502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 0919 SS=D	Continued from page 6	F 0919	conducted 3 x week for 2 weeks, then weekly x 4. All results will be reported to the QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395277	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025	
NAME OF PROVIDER OR SUPPLIER: HARBORVIEW REHABILITATION AND CARE CENTER AT DOYLESTOWN STATE LICENSE NUMBER: 040502		STREET ADDRESS, CITY, STATE, ZIP CODE: 432 MAPLE AVENUE DOYLESTOWN, PA 18901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 0919 SS=D	Continued from page 7 Based on observation, resident interview, and staff interview, it was determined that the facility failed to provide a working call bell for four of six residents (Residents 1, 2, 5, 6) on one of three nursing units. (First Floor) Findings include: Clinical record review revealed that Resident 1 had diagnoses that included heart disease and diabetes. The Minimum Data Set (MDS) assessment dated December 6, 2024, indicated that the resident was alert and oriented. Observation on February 5, 2025, at 11:00 a.m. through 12:15 p.m., revealed that the call light above resident room 107 was lit, but there was no audible alert. In an interview at 11:00 a.m., Resident 1 stated that his call bell did not work and that staff did not respond to the light because there was no sound. Clinical record review revealed that Resident 5 had diagnoses that included adult failure to thrive and diabetes. Review of nursing documentation dated	F 0919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395277	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025
NAME OF PROVIDER OR SUPPLIER: HARBORVIEW REHABILITATION AND CARE CENTER AT DOYLESTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE: 432 MAPLE AVENUE DOYLESTOWN, PA 18901		
STATE LICENSE NUMBER: 040502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 0919 SS=D	Continued from page 8 February 1, 2025, indicated that the resident was alert and oriented and able to make his needs known to staff. Observation on February 5, 2025, at 12:15 p.m., revealed that the call light above resident room 107 was lit, but there was no sound when activated. In an interview at 12:10 p.m., Resident 5 stated that his call bell did not work. Clinical record review revealed that Resident 6 had diagnoses that included major depressive disorder and anxiety. The MDS assessment dated January 7, 2025, indicated that the resident was alert and oriented. Observation on February 5, 2025, at 11:10 a.m. through 12:15 p.m., revealed that the call light above resident room 107 was lit, but there was no call bell sounding from the room. In an interview at 11:10 a.m., Resident 6 stated that the call bell did not work, that the light stayed on all the time, and that it had not worked for "a while." Clinical record review revealed that Resident 2 had diagnoses that included sepsis (infection). Review of nursing documentation dated January 30, 2025,	F 0919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395277	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025
NAME OF PROVIDER OR SUPPLIER: HARBORVIEW REHABILITATION AND CARE CENTER AT DOYLESTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE: 432 MAPLE AVENUE DOYLESTOWN, PA 18901		
STATE LICENSE NUMBER: 040502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 0919 SS=D	Continued from page 9 indicated that the resident was alert and oriented and able to make her needs known to staff. Observation on February 5, 2025, at 11:20 p.m., revealed that in resident room 104, the call bell for the bed by the window was unplugged and laying on the floor near the heating vent. In an interview at that time, Resident 2 stated, that the call bell did not work even if it was plugged in to the wall. In an interview on February 5, 2025, at 10:35 a.m., the Director of Nursing stated that there had been an issue with the call bell system not working on a consistent basis on the First Floor nursing unit for "a while." 28 Pa. Code 201.18(b)(3)(e)(2.1) Management. 28 Pa. Code 211.12(d)(5) Nursing services.	F 0919		
F 0921 SS=D		F 0921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395277	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025	
NAME OF PROVIDER OR SUPPLIER: HARBORVIEW REHABILITATION AND CARE CENTER AT DOYLESTOWN STATE LICENSE NUMBER: 040502		STREET ADDRESS, CITY, STATE, ZIP CODE: 432 MAPLE AVENUE DOYLESTOWN, PA 18901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 0921 SS=D	Continued from page 10 483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:	F 0921	1. Maintenance will start to repair the hole in the wall behind the toilet in the bathroom and replace the damaged ceiling tile near the vent in the bathroom. The bathroom floor will be cleaned and replace missing floor tiles as needed. Housekeeping cleaned the toilet bowl and removed the trash and basin from the tub in room 107. Maintenance will re-hang the paper towel holder. Nursing will remove the items stored on the window sill in room 107 and assist the resident in organizing their dresser. Facility will replace the over the bed table in room 107. Linen from the second bed were removed and replaced with clean linen. Maintenance department will replace ceiling tiles that are stained or missing in the first floor dining room. Housekeeping will clean the bathroom floor in room 101. Maintenance will re-affix the seven tiles to the bathroom wall in bathroom 101. Housekeeping cleaned the toilet bowl and repaired the toilet seat in the same bathroom. Maintenance will repair the damaged	Completion Date: 03/07/2025 Status: APPROVED Date: 02/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395277	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025
NAME OF PROVIDER OR SUPPLIER: HARBORVIEW REHABILITATION AND CARE CENTER AT DOYLESTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE: 432 MAPLE AVENUE DOYLESTOWN, PA 18901		
STATE LICENSE NUMBER: 040502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 0921 SS=D	Continued from page 11	F 0921	<p>tile in room 108's bathroom and make repairs to the wall behind the toilet. Maintenance will re-hang a paper towel holder in room 104 bathroom and have the floor cleaned.</p> <p>2. The facility will conduct an audit of resident rooms and bathrooms to ensure a safe/comfortable/sanitary environment is maintained. NHA will work with Maintenance and Housekeeping departments to review the results and create a plan to address areas identified on this audit.</p> <p>3. Maintenance and Housekeeping staff will be re-educated on maintaining sanitary, functional, and comfortable environment.</p> <p>4. NHA/Designee will conduct environment rounds weekly x4 weeks, then as deemed necessary by the QAPI Committee. All results will be reported to the QAPI</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395277	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025	
NAME OF PROVIDER OR SUPPLIER: HARBORVIEW REHABILITATION AND CARE CENTER AT DOYLESTOWN STATE LICENSE NUMBER: 040502		STREET ADDRESS, CITY, STATE, ZIP CODE: 432 MAPLE AVENUE DOYLESTOWN, PA 18901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 0921 SS=D	Continued from page 12 Based on observation, it was determined that the facility failed to provide a sanitary, functional, and comfortable environment for residents on one of three nursing units. (First Floor) Findings include: Observations on February 5, 2025, from 11:00 a.m through 12:20 p.m., on the First Floor nursing unit revealed the following environmental issues: In resident room 107, there was a large hole in the wall behind the toilet in the bathroom. There was a ceiling tile near the vent in the bathroom that was damaged. There were stained and missing floor tiles throughout the bathroom floor. The floor tiles around the bottom of the toilet and under the sink were stained. The toilet bowl was soiled. There was a bath tub in the bathroom of room 107 that had a basin on top of it. The basin was filled with a bag of soiled linen. There was no paper towel holder in the bathroom.	F 0921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395277	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025	
NAME OF PROVIDER OR SUPPLIER: HARBORVIEW REHABILITATION AND CARE CENTER AT DOYLESTOWN STATE LICENSE NUMBER: 040502		STREET ADDRESS, CITY, STATE, ZIP CODE: 432 MAPLE AVENUE DOYLESTOWN, PA 18901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 0921 SS=D	Continued from page 13 In resident room 107, there were two boxes of wound dressing pads, two gallon jugs of sterile water, a box of gloves, a reacher, and other personal hygiene items stored on the window sill. In addition, the dresser near the window bed was overflowing with miscellaneous items on the top of the dresser and in the drawers. In an interview, the resident stated that he needed help to clean out the dresser and the window sill. The over-the-bed table for the first bed in room 107 was cracked and damaged. The bottom rungs of the table were soiled with a black substance. The sheets and comforter on the second bed in room 107 were stained. In the first floor dining room there were six stained ceiling tiles and one ceiling tile with a hole. There was also a large ceiling tile that was missing which exposed rusted pipes and wires. The tiles around the toilet in the bathroom of room	F 0921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395277	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025
NAME OF PROVIDER OR SUPPLIER: HARBORVIEW REHABILITATION AND CARE CENTER AT DOYLESTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE: 432 MAPLE AVENUE DOYLESTOWN, PA 18901		
STATE LICENSE NUMBER: 040502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 0921 SS=D	Continued from page 14 101 were stained. There were seven bathroom wall tiles that had fallen off the wall and were laying on the floor of the bathroom. The toilet bowl in this bathroom was soiled. The toilet seat was crooked and broken. The ceiling tile near the vent in the bathroom was damaged. The tiles on the bathroom floor of room 108 were damaged. The lower wall behind the toilet was damaged. The tiles in the bathroom of room 104 were stained and there was no paper towel holder in place. 28 Pa.Code 201.18(b)(1)(e)(2.1) Management.	F 0921		



Certified End Page

HARBORVIEW REHABILITATION AND CARE CENTER AT DOYLESTOWN

STATE LICENSE NUMBER: 040502

SURVEY EXIT DATE: 02/05/2025

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, 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