

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395405	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/07/2025
NAME OF PROVIDER OR SUPPLIER: QUAKERTOWN CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1020 SOUTH MAIN STREET QUAKERTOWN, PA 18951		
STATE LICENSE NUMBER: 691102				
(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 0584	Based on a Medicare/Medicaid Recertification, State Licensure, and a Civil Rights Compliance survey completed on February 7, 2025, it was determined that Quakertown 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 0584		
SS=E				

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 0584 SS=E	Continued from page 1 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	1. The fan in room 125, bed H, has been cleaned and dusted by the housekeeping staff. Housekeeping staff also cleaned the windowsill in room 133, the PTAC unit (ductless air conditioning unit) in room 135, the solid black substance in room 137, bed W, and the dust on the window and curtain in room 116. Room 123 had the closet doors replaced. Room 134 bed W the dresser drawer handle was repaired. Room 127 had the tile repaired and the ceiling tile replaced. Room 131 had the ceiling tile replaced. Room 133 had the wallpaper reglued to the wall. Rooms 120, 121, 129, and 131 will have marred walls repaired. Room 131 will have the hole repaired. Room 135 will have the bathroom floor redone. Room 98's bathroom wall and floor will be repaired. Room 109's floor will be replace in the area that was lifted away from the base. 2. The maintenance director and housekeeping director will conduct a building wide audit of walls, closet	Completion Date: 03/18/2025 Status: APPROVED Date: 02/24/2025

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F 0584 SS=E	Continued from page 2 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584	doors, floors and furniture for areas of repair needed. 3. The housekeeping director will reeducate housekeeping staff on maintaining standards of cleanliness of the building 4. Maintenance director and House Keeping director will conduct weekly audits of walls, closet doors, floors, and furniture in resident rooms for areas that need repaired x 8 weeks, Then monthly x2. Audits will be reviewed at the QAPI meeting for review or recommendations.	

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F 0584 SS=E	Continued from page 3 Based on observation, it was determined that the facility failed to provide a safe, clean, and comfortable environment for residents on two of two nursing units. (South Wing and North Wing) Findings include: Observation from February 4, 2025, between 9:45 a.m. and 1:35 p.m., February 5, 2025, between 8:20 a.m. and 9:00 a.m., and 12:15 p.m. and 2:21 p.m., and February 7, 2025, between 9:10 a.m. and 9:30 a.m. revealed the following: In room 120, the walls were heavily marred. In room 121, the walls were marred and the closet was missing both doors. In room 123, the closet was missing both doors. In room 125 bed H, the fan had a heavy accumulation of dust and dirt.	F 0584		

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F 0584 SS=E	Continued from page 4 In room 127's bathroom, there was a broken floor tile in front of the toilet and a water-stained ceiling tile. In room 129, the walls were heavily marred. In room 131, the walls were heavily marred. In the bathroom, there was a large hole in the drywall on the right side of the wall. There was a water-stained ceiling tile. In room 133, the windowsill was covered with dirt and debris. The wallpaper was peeling behind bed W. In room 134 bed W, the dresser drawer handle was broken. In room 135, the ptac unit (ductless air conditioning unit that heats and cools small areas) contained debris and dirt. In the bathroom, the floor was buckled on the left and right sides of the toilet	F 0584		

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F 0584 SS=E	Continued from page 5 In room 137 bed W, there was a solid black thick substance splattered on the floor. In room 98's bathroom, there was a brown stain along the bottom molding on the wall by the toilet and under the sink. There was a floor tile behind the toilet that was stained with a black substance. In room 116, there was an accumulation of dust in the top corner of the window as well as on the curtain. In room 109, a layer of floor material in the entry way was lifted away from the base. 28 Pa. Code 201.18(b)(3) Management.	F 0584		

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F 0641 SS=D	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	<p>1. The MDS of Resident 7 was modified.</p> <p>2. A house wide audit was conducted by CRC for resident's with completed MDS for the past 30 days to verify accuracy of coding of antipsychotic medications and weights.</p> <p>3. NPE or designee will re-educate the CRC on accurate coding of antipsychotic medications and weights on the MDS. Residents scheduled for MDS completion will be reviewed during clinical meeting to verify antipsychotic and weight accuracy.</p> <p>4. CRC and/or designee will conduct weekly audits of MDS completed weekly x 8, then monthly x 2 to verify accuracy antipsychotic medications and weight documentation. Audits will be reviewed at the QAPI meeting for review or recommendations.</p>	<p>Completion Date: 03/18/2025 Status: APPROVED Date: 02/24/2025</p>

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F 0641 SS=D	Continued from page 7 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the Minimum Data Set (MDS) assessment was completed to accurately reflect the current status of one of 26 sampled residents. (Resident 7) Findings include: Clinical record review revealed that Resident 7 had diagnoses that included bipolar disorder and heart failure. On May 17, 2024, the resident weighed 152.4 pounds. On November 1, 2024, the resident weighed 173.6 pounds, which reflected a significant weight gain of 13.9% in the last six months. Review of the physician's orders revealed that Resident 7 had been receiving an antipsychotic medication, olanzapine (a medication that affected brain activities) since May 17, 2024. Review of the November 2024 medication administration record revealed that Resident 7 received olanzapine during the MDS review period. The MDS assessment dated November 8, 2024, incorrectly indicated in section K that Resident 7's weight was 146 pounds,	F 0641		

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F 0641 SS=D	Continued from page 8 which was not a weight reflected in the resident's clinical record, and that the resident had no significant weight gain in the last six months. Further review of the MDS assessment revealed that section N incorrectly indicated that the resident did not receive an antipsychotic medication in the review period. In an interview on February 7, 2025, at 1:00 p.m., the Director of Nursing confirmed that Resident 7's MDS assessment areas were inaccurate.	F 0641		
F 0656 SS=D		F 0656		

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F 0656 SS=D	Continued from page 9 483.21(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	1. The care plans of Residents 112 and 115 were updated to reflect urinary incontinence. 2. Current residents identified with incontinence on the most recent MDS have been reviewed to verify incontinence needs are addressed in the care plan. 3. NPE or designee will reinservice licensed nursing staff on the process for developing careplans that address the individual resident needs as it relates to incontinence. 4. DON and/or designee will conduct weekly audits x 8, then monthly x 2 ofl residents identified with urinary incontinence to verify a care plan is in place. Results of the audits will be presented at the QAPI meetings for review and/or reommentations.	Completion Date: 03/18/2025 Status: APPROVED Date: 02/24/2025

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F 0656 SS=D	Continued from page 10 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 11 Based on clinical record review 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 two of 26 sampled residents. (Residents 112, 115) Findings include: Clinical record review revealed that Resident 112 was admitted to the facility on August 15, 2024, and had diagnoses that included chronic kidney failure. The Minimum Data Set (MDS) Care Area Assessment (CAA) summary dated August 24, 2024, noted that the resident's urinary incontinence was to be addressed in the care plan. The quarterly MDS summary dated November 7, 2024, indicated the resident was frequently incontinent of urine. There was no evidence that interventions to address Resident 112's urinary incontinence were included in the current care plan. Clinical record review revealed that Resident 115	F 0656		

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F 0656 SS=D	Continued from page 12 was admitted to the facility on September 7, 2024, and had diagnoses that included epilepsy (a brain disorder that causes seizures) and rheumatoid arthritis. The MDS CAA summary dated September 14, 2024, noted that the resident's urinary incontinence was to be addressed in the care plan. The quarterly MDS summary dated November 27, 2024, indicated that the resident was frequently incontinent of urine. There was no evidence that interventions to address Resident 115's urinary incontinence were included in the current care plan. In an interview on February 7, 2025, at 12:36 p.m., the Director of Nursing confirmed there was no documented evidence that the care areas were addressed in the residents' current care plans. CFR 483.21(b)(1) Comprehensive Care Plans Previously cited 3/8/2024 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.	F 0656		

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F 0656 SS=D	Continued from page 13	F 0656		
F 0697 SS=D		F 0697		

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F 0697 SS=D	Continued from page 14 483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0697	1. The PRN pain medication orders for Resident 20 were updated to include parameters of usage. 2. Current residents with orders for PRN pain medications have been reviewed to verify defined parameters are ordered. 3. NPE or designee will re-inservice licensed nurses on ensuring that PRN medications have proper defined parameters for administration. Residents with new orders for prn pain medications will be reviewed during clinical meeting to verify pain parameters are ordered. 4. DON and/or designee will conduct random audits weekly x 8, then monthly x 2 for all residents with PRN pain medications to ensure defined parameters are stated. Audits will be reviewed with the QAPI committee for any further actions or recommendations that may be necessary.	Completion Date: 03/18/2025 Status: APPROVED Date: 02/24/2025

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F 0697 SS=D	Continued from page 15 Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to provide person-centered pain management consistent with professional standards of practice for one of 26 sampled residents. (Resident 20) Findings include: Review of the facility policy entitled, "Pain Management Policy," last reviewed October 15, 2024, revealed that the physician ordered PRN (as needed) pain medications were to have defined parameters for use. Clinical record review revealed that Resident 20 had diagnoses that included chronic venous insufficiency (a condition in which the veins have problems sending blood from the legs back to the heart), lymphedema (tissue swelling caused by an accumulation of protein-rich fluid drained through the lymphatic system), and Parkinson's disease. There were physician's orders dated November 27,	F 0697		

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F 0697 SS=D	Continued from page 16 2024, for the resident to receive the narcotic pain medication tramadol every eight hours as needed for pain (failed to identify pain parameters), ibuprofen every eight hours as needed for pain (failed to identify pain parameters), and acetaminophen every four hours as needed for mild pain. Review of Medication Administration Records revealed that the resident received the as needed narcotic (tramadol) for mild or moderate pain on 35 occasions in December 2024, 23 in January 2025, and six in February 2025. The resident did not receive any doses of the as needed acetaminophen for mild pain or ibuprofen in December 2024, January 2025, or February 2025. In an interview on February 7, 2025, at 12:58 p.m., the Director of Nursing confirmed that parameters had not been ordered for the administration of the prn (as needed) pain medication. 28 Pa. Code 211.9(a)(1) Pharmacy services. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395405	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/07/2025
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NAME OF PROVIDER OR SUPPLIER: QUAKERTOWN CENTER STATE LICENSE NUMBER: 691102	STREET ADDRESS, CITY, STATE, ZIP CODE: 1020 SOUTH MAIN STREET QUAKERTOWN, PA 18951
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F 0697 SS=D	Continued from page 17	F 0697		
F 0698 SS=D		F 0698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395405	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/07/2025
NAME OF PROVIDER OR SUPPLIER: QUAKERTOWN CENTER STATE LICENSE NUMBER: 691102		STREET ADDRESS, CITY, STATE, ZIP CODE: 1020 SOUTH MAIN STREET QUAKERTOWN, PA 18951		
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F 0698 SS=D	Continued from page 18 483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0698	1. The facility is unable to correct the cited deficient practice for Resident 70 due to documentation was for an appointment that happened in the past. 2. Current residents receiving dialysis have been reviewed to verify completion of the pre-dialysis portion of the Hemodialysis Communication form. 3. NPE or designee will re-educate licensed nursing staff on completion of dialysis communication forms. Residents receiving dialysis will be reviewed during clinical meeting to verify completion of the hemodialysis communication forms. 4. DON and/or designee will conduct audits weekly x 8, then monthly x 2 for residents on dialysis to ensure communication forms are being completed. Results of the audits will be presented at the QAPI meetings for review and/or recommendations.	Completion Date: 03/18/2025 Status: APPROVED Date: 02/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395405	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/07/2025	
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F 0698 SS=D	Continued from page 19 Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to provide ongoing assessment and monitoring for one of one sampled residents receiving dialysis (process of removing excess toxins and water from the blood). (Resident 70) Findings include: A review of a facility policy entitled, "Dialysis: Hemodialysis- Communication and Documentation," last reviewed October 15, 2024, revealed that staff were to complete the pre-dialysis portion of the Hemodialysis Communication Record that provided information regarding the resident's ongoing status to send with the resident to dialysis. Clinical record review revealed that Resident 70 had diagnoses that included end-stage renal (kidney) disease and dependence on renal dialysis and had a physician's order for the facility to provide dialysis three days per week. There was a lack of evidence to support that the pre-dialysis portion of the	F 0698		

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F 0698 SS=D	Continued from page 20 resident's dialysis communication forms were completed and that the resident was assessed before dialysis on five of 14 occasions from January 4, 2025, through February 4, 2025. In an interview on February 7, 2025, at 9:35 a.m., the Director of Nursing confirmed that communication forms were to be completed before dialysis to assess residents and that the forms were not completed. 28 Pa. Code 211.12(1)(3)(5) Nursing services.	F 0698		

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F 0698 SS=D	Continued from page 21	F 0698		
F 0758 SS=D		F 0758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395405	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/07/2025	
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F 0758 SS=D	Continued from page 22 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 0758	1. The psychotropic medication orders for Residents 82 and 116 were reviewed by the provider for proper diagnosis. 2. Current residents receiving antipsychotic medications was conducted to verify the medications were prescribed for a specific diagnosis. Residents with new orders for anti-psychotic medications will be reviewed during clinical meeting to verify that the medicaion was prescribed for a specific diagnosis. 3. NPE or designee will re-inservice licensed nursing staff on ensuring that psychotropic medications have specific diagnosis for administration and usage. 4. DON and/or designee will conduct audits weekly x 8, then monthly x 2 for residents with antipsychotic medications to verify a proper diagnosis has been ordered. Results of the audits will be presented at the	Completion Date: 03/18/2025 Status: APPROVED Date: 02/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395405	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/07/2025	
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F 0758 SS=D	Continued from page 23 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 0758	QAPI committee for review and/or recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395405	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/07/2025
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F 0758 SS=D	Continued from page 24 Based on clinical record review and staff interview, it was determined that the facility failed to ensure psychotropic medications (medications that affect brain activities) were prescribed for a specific diagnosis for two of seven sampled residents who were prescribed psychotropic medications. (Residents 82, 116) Findings include: Clinical record review revealed that resident 82 had diagnoses that included Alzheimer's disease, anxiety, and stroke. A physician's order dated January 18, 2024, directed staff to administer an antipsychotic medication, Seroquel, at bedtime for agitation. There was a lack of evidence to support that the medication was used to treat a specific diagnosis. Clinical record review revealed that resident 116 had diagnoses that included post traumatic stress disorder (PTSD) and depression. Physician's orders dated January 25, 2025, directed staff to administer antipsychotic medications, haloperidol,	F 0758		

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F 0758 SS=D	Continued from page 25 every six hours for psychosis and quetiapine, twice daily for psychosis. There was a lack of evidence to support that the medication was used to treat a specific diagnosis. In an interview on February 7, 2025, at 1:11 p.m., the Director of Nursing confirmed that the antipsychotic medication orders should have included specific diagnoses. CFR 483.45(e)(1) Pharmacy Services Previously cited 3/8/2024 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.	F 0758		

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F 0758 SS=D	Continued from page 26	F 0758			

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P 5520	Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	<p>1. All residents received care in accordance with their plan of care and attending physician orders.</p> <p>2. The Clinical Leadership Team and scheduler review the schedule daily. In the event of call offs the facility follows staffing policies including exhausting all possible replacements from internal staffing pool and contracted agency staff. Facility continues to offer incentives, coordinate staffing schedules, and replace call-offs per policy while actively continuing to hire for all open positions and additional pool staff.</p> <p>3. All Nursing Staff have been educated on the 7/1/2024 Nursing Ratios and PPD requirements and the importance of maintaining the schedule as posted.</p> <p>4. To monitor and maintain ongoing compliance the DON or designee will audit staffing weekly x4 weeks then monthly for two months. Results will be taken to the QAPI for review and revision as needed.</p>	<p>Completion Date: 03/18/2025 Status: APPROVED Date: 02/24/2025</p>
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE:		(X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395405	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/07/2025
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P 5520	Continued from page 1 Based on a review of nursing time schedules, it was determined that the facility failed to meet the minimum nurse aide (NA) to resident ratios for eight of 21 days reviewed. Findings include: Review of nursing schedules for 21 days from December 22 through 28, 2024, January 5 through 11, 2025, and January 31, 2025, through February 6, 2025, revealed the following: The facility failed to meet the minimum NA to resident ratio of one NA for ten residents on the day (7:00 a.m. through 3:00 p.m.) shift on February 2, 2025. The facility failed to meet the minimum NA to resident ratio of one NA for 11 residents on the evening (3:00 p.m. to 11:00 p.m.) shift on December 24 and 25, 2024. The facility failed to meet the minimum NA to	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395405	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/07/2025
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P 5520	Continued from page 2 resident ratio of one NA for 15 residents on the night (11:00 p.m. to 7:00 a.m.) shift on December 25, 2024, January 5, 6, 7, and 11, 2025, and February 1 and 2, 2025.	P 5520		
P 5530		P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395405	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/07/2025
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P 5530	Continued from page 3 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	<ol style="list-style-type: none"> All residents received care in accordance with their plan of care and attending physician orders. The Clinical Leadership Team and scheduler review the schedule daily. In the event of call offs the facility follows staffing policies including exhausting all possible replacements from internal staffing pool and contracted agency staff. Facility continues to offer incentives, coordinate staffing schedules, and replace call-offs per policy while actively continuing to hire for all open positions and additional pool staff. All Nursing Staff have been educated on the 7/1/2024 Nursing Ratios and PPD requirements and the importance of maintaining the schedule as posted. To monitor and maintain ongoing compliance the DON or designee will audit staffing weekly x4 weeks then monthly for two months. Results will be taken to the QAPI for 	Completion Date: 03/18/2025 Status: APPROVED Date: 02/24/2025

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P 5530	Continued from page 4	P 5530	review and revision as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395405	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/07/2025
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P 5530	Continued from page 5 Based on review of nursing time schedules, it was determined that the facility failed to meet the minimum licensed practical nurse (LPN) to resident ratios for two of 21 days reviewed. Findings include: Review of nursing schedules for 21 days from December 22 through 28, 2024, January 5 through 11, 2025, and January 31, 2025, through February 6, 2025, revealed the following: The facility failed to meet the minimum LPN to resident ratio of one LPN for 25 residents on the day (7:00 a.m. to 3:00 p.m.) shift on February 2, 2025. The facility failed to meet the minimum LPN to resident ratio of one LPN for 30 residents on the evening (3:00 p.m. to 11:00 p.m.) shift on February 2, 2025.	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395405	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 02/07/2025
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P 5530	Continued from page 6 The facility failed to meet the minimum LPN to resident ratio of one LPN for 40 residents on the night (11:00 p.m. to 7:00 a.m.) shift on December 22, 2024.	P 5530			
P 5640		P 5640			

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(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
P 5640	Continued from page 7 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	<ol style="list-style-type: none"> All residents received care in accordance with their plan of care and attending physician orders. The Clinical Leadership Team and scheduler review the schedule daily. In the event of call offs the facility follows staffing policies including exhausting all possible replacements from internal staffing pool and contracted agency staff. Facility continues to offer incentives, coordinate staffing schedules, and replace call-offs per policy while actively continuing to hire for all open positions and additional pool staff. All Nursing Staff have been educated on the 7/1/2024 Nursing Ratios and PPD requirements and the importance of maintaining the schedule as posted. To monitor and maintain ongoing compliance the DON or designee will audit staffing weekly x4 weeks then monthly for two months. Results will be taken to the QAPI for 	Completion Date: 03/18/2025 Status: APPROVED Date: 02/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395405	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/07/2025
NAME OF PROVIDER OR SUPPLIER: QUAKERTOWN CENTER STATE LICENSE NUMBER: 691102		STREET ADDRESS, CITY, STATE, ZIP CODE: 1020 SOUTH MAIN STREET QUAKERTOWN, PA 18951		
(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
P 5640	Continued from page 8 Based on a review of nursing time schedules, it was determined that the facility failed to provide a minimum of 3.2 direct care hours for each resident for three of 21 days reviewed. Findings include: Review of nursing schedules for 21 days from December 22 through 28, 2024, January 5 through 11, 2025, and January 31, 2025, through February 6, 2025, revealed the following: December 25, 2024: 2.97 care hours per resident. February 1, 2025: 2.97 care hours per resident. February 2, 2025: 2.90 care hours per resident.	P 5640	review and revision as needed.	



Certified End Page

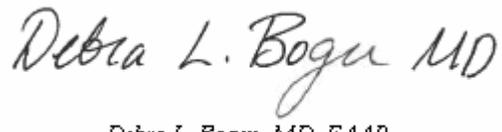
QUAKERTOWN CENTER

STATE LICENSE NUMBER: 691102

SURVEY EXIT DATE: 02/07/2025

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