STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395431	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MAJESTIC OAKS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **558802**	**333 NEWTOWN ROAD WARMINSTER, PA 18974**

(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 March 20, 2025, it was determined that Majestic Oaks Rehabilitation And Nursing 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 as they relate to the Health portion of the survey.	F 0000		
F 0577 SS=E		F 0577		

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 0577 SS=E	Continued from page 1 483.10(g)(10)(11) Right to Survey Results/Advocate Agency Info §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by:	F 0577	1. Updated survey results book Added survey books to 2nd, 3rd and 4th floor nurses station. All residents have been updated on status of where survey books are located. 2. Survey book location will be added - Flyer in elevator - Admissions Welcome Packet - Reviewed at Residents Council 3. Education provided to medical records who will keep survey books up to date adding the most recent surveys upon receipt of letter/2567 Education provided to staff as to where survey book is so that when residents ask they know where to find. 4. Random audits by the Administrator /designee once a week for one	Completion Date: **05/14/2025** Status: **APPROVED** Date: **04/11/2025**

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F 0577 SS=E	Continued from page 2	F 0577	month twice a week for one month and then once a month for one month to ensure residents are aware where to find survey results and that the survey books are located in lobby, and nurses station on 2, 3 and 4. Results of the audits will be presented for review at the monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months.	

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F 0577 SS=E	Continued from page 3 Based on a review of the facility policy, observations, and an interview with staff, it was determined that the facility failed to ensure that the most recent Department of Health Survey results were readily accessible to residents and visitors in three of three nursing floors and lobby (Second Floor, Third Floor, and Fourth Floor). Findings include: The facility's policy titled "Examination of Survey Results," dated April 27, 2017, states, "Survey reports and plans of correction are readily accessible to residents, family members, resident representatives, and the public." It further specifies under Bulletin 2: "A copy of the most recent survey report and any plans of correction are kept in a binder in the resident's day room." During a resident council meeting held on March 18, 2025, at 10:30 a.m., with 12 residents (R62, R13, R35, R129, R70, R49, R6, R4, R96, R92, R93), who were identified as alert and oriented, it was	F 0577		

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F 0577 SS=E	Continued from page 4 revealed that the residents were unaware of the recent Department of Health Survey results. On March 19, 2025, at 9:31 a.m., a facility tour was conducted with the Director of Social Services, Employee E4, to observe the placement of the Department of Health Survey binder in the facility. Upon observing the lobby, it was noted that the Department of Health Survey results binder was outdated, with the last survey results recorded as of November 2024. Additionally, the second, third, and fourth-floor nursing units did not have survey result binders available. On March 19, 2025 at 2:45 p.m., during an interview with the Administrator, Employee E1 confirmed that the facility possessed two more recent Department of Health Survey results, but these were not included in the binder in the front lobby. 28 Pa. Code 201.14(a) Responsibility of licensee	F 0577		

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F 0584 SS=E		F 0584		

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F 0584 SS=E	Continued from page 6 483.10(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. Room 414 mattress replaced. Room 414 ceiling tiles replaced. 413 mirror in restroom hung up. 413 added baseboards to bottom of wall in restroom. 404 picture that was not hung was removed from room. 404 cleaned up substance on floor 409 replaced ceiling tile Removed broken sanitizer across from dayroom on 4th floor near 409 409 cleaned 418 fixed baseboard next to entrance 418 fixed drywall 312 fixed hole in bathroom wall and cleaned up drywall from bathroom floor. Items needed for kitchen to allow not to run out ordered. after 2nd floor R82 and R366 were served lunch on paper plates. 12nd floor R1 served thickened juice in Styrofoam cup. Test tray was served with coffee in Styrofoam cup.2nd floor R141 and R111 served coffee in strofoam cups. 2.	Completion Date: **05/14/2025** Status: **APPROVED** Date: **04/15/2025**

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F 0584 SS=E	Continued from page 7 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	Audit of the whole facility completed that includes - Mattresses - Ceiling tiles - Unhung items - Missing mirrors in bathroom - Missing / damaged baseboards - Dirty floors - Sanitizers - Odor smelly - Drywall damage To identify any additional items that need to be repaired. Audit / count of current dining needs including cups and plates and order what is needed. 3. Educate - All nursing care staff to notify Maintenance / Administration of any mattresses that need of repair/replacement/smelly. Along with any rooms that have items in that need addressing. - Educate Maintenance Staff that rounding should include all areas noted	

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F 0584 SS=E	Continued from page 8	F 0584	o Ceiling tiles o Unhung items o Missing mirrors o Damaged baseboards o dirty floors o sanitizers need replacement o odorous rooms o drywall damage. - All staff educated that using paper products is not part of a homelike environment and need to be avoided for this reason as well as for safety. Administration must be notified if there is a need to use paper products. 4 Random audits by the Administrator/designee to ensure that Maintenance Rounds are being completed on the whole facility, items being added to work list and work list is being worked on once a week for one month. twice a week for one month and once a month for one month. Random audits by the Administrator/designee to ensure	

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F 0584 SS=E	Continued from page 9	F 0584	that paper products are being avoided to promote homelike environment and safety once a week for one month. twice a week for one month and once a month for one month. The findings of the audits will be brought to the Quality monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

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F 0584 SS=E	Continued from page 10 Based on observations, interviews with residents and staff, and review of the facility policy, it was determined that the facility failed to provide a clean, safe, comfortable and homelike environment in three of the three nursing units observed (2nd, 3rd, 4th floor Nursing Units). Findings include: A review of the facility policy titled "Homelike Environment" revised February 2021, revealed " Residents are provided with a safe, clean and comfortable and homelike environment and encouraged to use their personal belongings to the extend possible". It further states, "these characteristics include clean, sanitary and orderly environment, clean bed, bath linens that are in good condition, pleasant, neutral scents". On March 17, 2025, at 11:47 a.m., an interview with Resident R146 who lives in room 414 revealed that his mattress is peeling, and he collects the peeling material in a cup. Additionally, observation	F 0584		

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F 0584 SS=E	Continued from page 11 showed that there are five ceiling tiles with large brown stains. On March 17, 2025, at 11:51 a.m., an observation in room 413 reveled no restroom mirror and restroom are missing baseboard on the bottom of the wall. On March 17, 2025, at 11:58 a.m., observation in room 404 had a large picture leaning against the wall does not hang up, large brown substance that is spilled on the floor between the two beds. On March 17, 2025, at 12:16 p.m., observation next to room 409 has a hole in the tile ceiling. Day room which as across had a broken sanitizer with no cover. Room 409 had a urine odor. License nurse, Employee E5 confirmed these observations. On March 17, 2025, at 12:38 p.m., a tour with the Maintenance Director, Employee E6 confirmed the above observations in room 414, 413, 404, 409 and 418 had broken baseboard that was not	F 0584		

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F 0584 SS=E	Continued from page 12 attached to the wall next to the entrance door and dry wall was peeling off from the wall. On March 18, 2025, at 12:09 p.m., observation in room 312 revealed a hole in the bathroom wall, exposing insulation. Drywall was also obsvered on the bathroom floor. Observations on March 17, 2025, at 12:53 p.m. in the 2nd floor dining room during the lunch time meal revealed Resident R82 and R366 were served lunch on paper plates. Interview with nurse aide, Employee E6, confirmed residents received paper products and was not sure why. Further observations on March 17, 2025, at 1:50 p.m. revealed Resident R1, in room 209D, was served thickened juice in a Styrofoam cup. The beverage was leaking through the bottom of the cup, creating a sticky mess on the residents overbed table where he was eating. Interview with nurse aide, Employee E6, confirmed the observations and was unsure why resident was served in a Styrofoam	F 0584		

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F 0584 SS=E	Continued from page 13 cup. During a test tray on the 2nd floor nursing unit with the Food Service Director, Employee E5, on March 19, 2025, at 12:28 p.m., coffee was served in a Styrofoam cup. The Food Service Director, Employee E5, reported the kitchen is short on coffee mugs and subsequently the second floor (last unit to be served lunch) would be served in Styrofoam cups. Observations on March 20, 2025, at 12:50 p.m. revealed Resident R141 and R111, who both resided on the 2nd floor, were served coffee in Styrofoam cups. 28 Pa Code 201.18(b)(1)(3)Management	F 0584		
F 0585 SS=D		F 0585		

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F 0585 SS=D	Continued from page 14 483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance	F 0585	1. Social Services met with R4, R6, R13, R35, R49, R62, R70, R92, R93, R96, R129 to discuss any grievances they have had within that they did not have the outcome of. R30 grievance and that it was resolved and that she was given clothing to wear. Outcome. 2. Reviewed Grievances dated March 1 to current and met with residents / person who initiated the grievance to ensure they are aware of outcome of grievance. 3. Education provided to Social Services and All Department Heads that All Grievance outcomes will be reviewed with the resident / person that initiated the grievance and will have sign off that it was reviewed. 4. Random audits by the	Completion Date: **05/14/2025** Status: **APPROVED** Date: **04/14/2025**

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F 0585 SS=D	Continued from page 15 can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the	F 0585	Administrator/designee to ensure that Grievance outcomes are being reviewed and signed off on with the resident / person initiated once a week for one month. twice a week for one month and once a month for one month. The findings of the audits will be brought to the Quality monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395431	A. BLDG: __00_____ B. WING: _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0585 SS=D	Continued from page 16 date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by:	F 0585		

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F 0585 SS=D	Continued from page 17 Based on a resident group interview, resident interview, review of facility policy and staff interview, it was determined that the facility failed to ensure that prompt efforts were made to resolve grievances for one of thirty-one residents (Resident R30) and effectively communicate the resolutions of grievances for 11 of thirty-one residents (R4, R6, R13, R35, R49, R62, R70, R92, R93, R96, R129) Findings include: A review of the facility policy titled "Grievances/Complaints, Filing", revised on April 2023, stated under Policy Statement "The administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative." Further review, in section Policy Interpretation and Implementation, part 12, it states that "The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed (verbally and in writing) of the finding of the investigation and the actions that will be taken to correct any identified problems"	F 0585		

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F 0585 SS=D	Continued from page 18 Review of Facility document titled "Grievance Form", updated on April 6, 2017, revealed that "All grievance forms must be resolved within 7 days from the original date of notification from the department that is responsible." During a Resident Council meeting on March 18, 2025 at 10:30 a.m., 11 residents (R62, R13, R35, R129, R70, R49, R6, R4, R96, R92, R93), all of whom were alert and oriented, expressed concerns that when they file grievances, the facility does not provide them with information regarding the resolution after the investigation is completed. Review of Resident R30's clinical record revealed that Resident R30 was admitted to the facility on September 30, 2024 with diagnoses of but not limited to Heart Failure, Cellulitis (bacterial infection of the skin and the tissue beneath the skin), and Type 2 Diabetes (failure of the body to produce insulin).	F 0585		

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F 0585 SS=D	Continued from page 19 Review of R30's MDS (Minimum Data Set-assessment of resident care needs) Section C-Cognitive Problems, dated January 23, 2025, revealed that the Resident had a BIMS (Brief interview for metal status) score of 15 (intact cognitive response). Interview with Resident R30 on March 18, 2025 at 10:03 am, revealed Resident R30 was missing clothing. Resident stated that clothing was taken to be washed and never returned to her. The resident filed a grievance, but it has not been resolved and she has been using hospital gowns because she doesn't have any other belongings with her. Review of Resident R30's Grievance Form, dated February 25, 2025, confirmed the clothing was sent to laundry in a bag labeled with her name and room number on it and was not returned to the resident. Further review, under Plan for Resolution stated "Social worker met with Resident R30 who picked a new outfit out of catalog".	F 0585		

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F 0585 SS=D	Continued from page 20 Follow up interview with Resident R30 on March 19, 2025 at 10:25 am, revealed over 2 weeks ago, Social Worker met with Resident to choose items out of catalog. Resident confirmed that items were selected and provided to the social worker for purchase. Interview with Social Worker, Employee E3 on March 19, 2025 at 10:39 am, confirmed that grievance was placed on February 25, 2025. Further confirmed clothing has not been ordered. 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a)Resident rights	F 0585		
F 0604 SS=D		F 0604		

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F 0604 SS=D	Continued from page 21 483.10(e)(1), 483.12(a)(2) Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.	F 0604	1. Resident R-5 bed was removed from the wall and is now centered in the room. 2. All residents' beds will be assessed to identify and possible restraints to ensure the functional status of the residents and to determine the use of a restraint. 3. Nurse Educator/Designee will re-educate the professional nursing staff on the policy, "Use of Restraints." 4. The DON/Designee will conduct weekly random audits times 2 months to ensure residents with beds against the wall are assessed properly for use of a restraint. 5. Audit results will be reviewed monthly by QAPI Committee.	Completion Date: **05/14/2025** Status: **APPROVED** Date: **04/14/2025**

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F 0604 SS=D	Continued from page 22 This REQUIREMENT is not met as evidenced by:	F 0604		

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F 0604 SS=D	Continued from page 23 Based on review of facility policy, clinical record review, observations, and staff interviews, it was determined that the facility failed to identify the placement of beds against the wall as a restraint and failed to assess the functional status of an individual resident to determine the use of the restraint for one of 31 residents reviewed. (Residents R5). Findings Include: Review of facility policy titled "Use of Restraints", revised 2017, revealed the definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which staff applied it given that resident's physical condition (i.e, side rails are put back down, rather than climbed over), and this restricts his/her typical ability to change position or place, that device is considered a restraint. Clinical record review revealed Resident R5 was admitted to the facility May 24, 2022 with a diagnosis that included but not limited to hemiplegia	F 0604		

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F 0604 SS=D	Continued from page 24 and hemiparesis affecting left non-dominant side (muscle weakness on one side of the body), acute respiratory failure (inability of lungs to exchange oxygen and carbon dioxide properly, causing insufficient oxygen in the blood), and abnormal posture. Observation on March 18, 2025 at 9:28 a.m. revealed Resident R5 lying in bed and the bed (right side) against the wall. Review of Resident R5's nursing progress note, dated February 4, 2025 at 9:36 a.m., revealed resident bed will be adjusted and padded to avoid resident irritating wound by rubbing it against the wall Review of Resident R5's nursing progress note, dated February 18, 2025 at 7:54 a.m., revealed during change of shift around 11:15 p.m. resident was heard calling for 3-11 nursing aide. When nurse entered the room, resident was found on the floor in a fetal position between the bed and the	F 0604		

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F 0604 SS=D	Continued from page 25 wall. Resident aware of the fall, but not how it happened in detail. Further review of Resident R5's nursing progress note, dated February 18, 2025 at 11:01 a.m., revealed resident bed was against the wall. Resident pushed with legs pushing bed away from wall. Resident fell between bed and wall. The resident was returned to bed via mechanical lift. Interview on March 18, 2025 at 9:30 a.m. with Licensed Practical Nurse, Employee E7, confirmed Resident R5's bed was against the wall. 28 Pa. Code 211.8(e)(f) Use of Restraints. 28 Pa. Code:211.12(d)(1)(5) Nursing services.	F 0604		
F 0607 SS=D		F 0607		

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F 0607 SS=D	Continued from page 26 483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.	F 0607	1. Abuse In-Service training was provided to E4 who signed the acknowledgement form that it was provided and answered the questions. 2. Review all new hires back to Jan 1, 2025 to ensure that all staff hired since Jan 1 have had abuse training, questions answered and signed education on file. 3. Education provided to HR and all Department Heads that Abuse Training must be completed upon hire, and that in-service sheet must be signed. 4. Random audits by the Administrator/designee of new hires to ensure that Abuse in service training has been completed and in-service sheet has been signed once a week for one month. twice a week for one month and once a	Completion Date: **05/14/2025** Status: **APPROVED** Date: **04/14/2025**

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F 0607 SS=D	Continued from page 27 This REQUIREMENT is not met as evidenced by:	F 0607	month for one month. The findings of the audits will be brought to the Quality monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

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F 0607 SS=D	Continued from page 28 Based on facility policy review, personnel file review, and staff interview, it was determined that the facility failed to perform Elder Abuse and Resident Rights training upon hire for one of five personnel files reviewed (Employee E4). Findings Include: Review of the personnel file for Cook, Employee E4 on March 20, 2025 at 12:02 pm revealed employee hire date on December 5, 2024. Further review indicated that there was no documented evidence for completion of Elder Abuse training upon hire. An interview was conducted with Business Office/ HR, Employee E5, on March 20, 2025 at 12:13 pm, confirmed Employee E4's Elder Abuse training incomplete. 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 201.19(8) Personnel policies and procedures	F 0607		

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F 0607 SS=D	Continued from page 29	F 0607		
F 0623 SS=D		F 0623		

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F 0623 SS=D	Continued from page 30 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)	F 0623	1. The Office of the Ombudsman was notified that R102 was discharged to the hospital on 7/7/24 And that R102 was discharged to the hospital on 12/18/24 and that these residents were left off due to incorrect report pulled. 2. Correct Report pulled from PCC that included bed holds for residents discharged from 1/1/25 to current and resent to the Office of the Ombudsman. 3. Education provided to Social Services and Clinical Mgt Staff on what report to pull and that should include bed holds. 4. Random audits by the Administrator/designee of all discharges to ensure all are on the notification sent to Office of the Ombudsman once a week for three	Completion Date: **05/14/2025** Status: **APPROVED** Date: **04/14/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395431	A. BLDG: 00 B. WING:	03/20/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MAJESTIC OAKS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **558802**	**333 NEWTOWN ROAD WARMINSTER, PA 18974**

(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 0623 SS=D	Continued from page 31 (1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 0623	months. The findings of the audits will be brought to the Quality monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0623 SS=D	Continued from page 32 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by:	F 0623		

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F 0623 SS=D	Continued from page 33 Based on clinical record review, it was determined that the facility failed to notify the representative of the Office of the State Long Term Care Ombudsman for one of 31 residents sampled who were transferred to the hospital. (Resident R102). Finding includes: Resident R102 was initially admitted to the facility on October 14, 2022, diagnosed with spastic quadriplegic (partial or complete paralysis of all limbs), cerebral palsy (condition that affect movement and posture), major depressive and anxiety disorder, dysphagia (difficulty swallowing). On July 7, 2024, Resident R102 had an unplanned transfer to the hospital and a surgical gastrostomy (a surgical tube place in the abdominal wall and into the stomach used to provide nutrients and medications when a person cannot eat or drink adequately) was performed. Further review of the resident's clinical record	F 0623		

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F 0623 SS=D	Continued from page 34 revealed on December 18, 2024 Resident R102 had an unplanned transfer to the hospital due to stomach pain. On March 20, 2025, at 11:43 a.m., the Nursing Home Administrator confirmed that no written notices of the transfers was given to the State Long Term Care Ombudsman upon transfer out of the facility for Resident R102. 28 Pa. Code 201.29(h) Resident rights	F 0623		
F 0644 SS=D		F 0644		

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F 0644 SS=D	Continued from page 35 483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by:	F 0644	1. R71 and R98 PASARR Forms updated with the additional mental health diagnosis. 2. Audit of all residents to ensure that PASARRs capture mental health diagnosis 3. Education to Social Services and Clinical Team that all mental health dx must be on PASARR and if there is an addition it must be added. 4. Random audits by the Administrator/designee of 5 residents to ensure PASARR includes all mental health dx. once a week for one month. twice a week for one month and once a month for one month. The findings of the audits will be brought to the Quality monthly Quality Assurance Improvement Committee (QAPI) meeting monthly	Completion Date: **05/14/2025** Status: **APPROVED** Date: **04/14/2025**

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F 0644 SS=D	Continued from page 36	F 0644	for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0644 SS=D	Continued from page 37 Based on review of clinical records, interview with staff and review of facility policy, it was determined that the facility did not ensure revisions were made to the PASRR (Pre-Admission Screening and Resident Review) application to include mental health diagnoses for 2 out of 2 residents reviewed. (Resident R71, R98) Findings include: Review of the facility policy titled "Preadmission Screening and resident Review (PASRR)" policy last revised October 2023 revealed "New admissions and readmissions are screened for mental disorders (MD), intellectual disability (ID) or related disorders (RD) per the Medicaid Pre-Admission Screen for all potential admission, regardless of payer source, to determine if the individual meets the criteria for a MD, IM, RD. Review of Resident R71's PASRR completed on July 27, 2023, indicated that Resident R71 only had a mental health condition of Mood Disorder and	F 0644		

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F 0644 SS=D	Continued from page 38 Major Depressive Disorder. Review of R71's clinical record revealed on August 31, 2023, obtained a medical diagnosis Psychosis (is a mental health condition characterized by a disconnection from reality), physiological condition, Psychotic disorder, Suicidal Behavior and Psychotic disorder with Delusions. A review of Resident R98's PASRR completed on June 6, 2022, indicated that Resident R98 had a mental health condition of bipolar and schizoaffective disorder. A review of the Resident diagnosis revealed that he also had anxiety disorder as of August 11, 2023. Interview with the facility Social Worker, Employee E4 on March 19, 2025, at 10:36 a.m., confirmed that the PASSR forms for Residents: R71 and R98, should have been updated with the additional updated mental health diagnosis. 28 PA Code 211.10 (c) Resident Care Policies	F 0644		

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F 0644 SS=D	Continued from page 39 28 PA Code 211.5(f)(viii) Medical records	F 0644		
F 0656 SS=D		F 0656		

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F 0656 SS=D	Continued from page 40 483.21(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. Resident R-37 has a care plan in place for Diabetes. Resident R-115 has a care plan in place for respiratory needs. Resident R-97, R-75, and R-136 have care plans in place for use of Psychotropic medications. 2. All residents with diagnosis of Diabetes, use of Psychotropic medications, and respiratory needs will have a comprehensive care plan with interventions to address resident care needs. 3. Nurse Educator/Designee will re-educate the professional nursing staff on the policies, "Care Plan Comprehensive Person-Centered, Diabetes, and Psychotropic Medication." 4. The DON/Designee will conduct weekly random audits times 2 months to ensure residents with	Completion Date: **05/14/2025** Status: **APPROVED** Date: **04/14/2025**

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F 0656 SS=D	Continued from page 41 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	diagnosis of Diabetes, Respiratory needs, or use of Psychotropic Medications have a comprehensive care plan with interventions to address their care needs in place. 5. Audit results will be reviewed monthly by QAPI Committee.	

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F 0656 SS=D	Continued from page 42 Based on review of facility policy, facility documents, clinical records, and interview with staff, it was determined the facility failed to develop a comprehensive care plan and interventions to address resident care needs for Resident R37's diagnosis of diabetes, Resident R115 respiratory care, Resident R97 mood, R75 and R136 psychotropic medication, for five of 31 residents reviewed (Resident R37, R115, R136, R97, and R75). Findings include: Review of facility policy titled " Care Plan, Comprehensive Person-Center" revised March 2022, revealed the " a comprehensive, person-center care plan that includes measurable objectives and timetable to meet the resident's physical psychosocial and functional needs is developed and implemented for each resident. Review of Resident R37's clinical record revealed the resident was admitted to the facility on January	F 0656		

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F 0656 SS=D	Continued from page 43 10, 2025, diagnosed with Diabetes (failure of the body to produc insulin) with orders for insulin and Accu-Cheks three times a day at 8:00 a. m., 12:00 p.m. and 5:00 p.m. Further review of Resident R37 clinical record failed to develop a care plan related to Resident R37 diagnosis of diabetes. On March 20, 2025 at 10:00 a.m the Director of Nursing confirmed a care plan was not developed for Resident R37's diagnosis of Diabetes. . A review of a clinical record for Resident R115 revealed an admission on June 20, 2022, with a diagnosis of diffuse traumatic brain injury. A review of the physician order dated February 17, 2025 "oxygen as needed to maintain 02 (oxygen) level above 92% at 2 /min via N/C (nasal cannula) PRN (as needed) SOB (shorthness of breath) every shift". On March 17, 2025, at 12:06 p.m., it was observed that Resident R115 had oxygen set at 2.5 liters per	F 0656		

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F 0656 SS=D	Continued from page 44 minute via nasal cannula. A review of the comprehensive care plan dated last revised February 14, 2025, did not reveal a care plan for oxygen therapy. On March 19, 2025, at 2:14 p.m. the Director of Nursing, Employee E2 confirmed there was no care plan for oxygen therapy for Resident R115. A review of the clinical record for Resident R136 revealed an admission date of July 12, 2024, with diagnoses including dementia (severity unspecified), without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and depression. A review of the physician's order dated November 1, 2024, shows that Resident R136 was prescribed Seroquel 50 milligrams (mg) oral tablet as an antipsychotic medication. On March 19, 2025, at 10:03 a.m. an interview with the unit manager, Employee E3 confirmed that there was no comprehensive care plan developed	F 0656		

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F 0656 SS=D	Continued from page 45 for the antipsychotic medication for Resident 136. Review of Resident R75's clinical record revealed an admission on February 11, 2025 with a diagnosis of bipolar disorder and anxiety disorder. Review of Resident R75's clinical record revealed a physician order dated March 4, 2025, Alprazolam (used to treat anxiety and panic disorders) 0.5mg three times a day and Aripiprazole (used to treat agitation) 15 mg daily. Continued review revealed a physician order dated February 5, 2025, Lamotrigine (helps to prevent extreme mood swings related to bipolar) 10 0mg twice daily. Interview with Resident R75 revealed resident expressing concerns about "non-interest in activities" and appearing in an anxious mood. Further review of Resident R75's clinical record revealed a physician note dated March 9, 2025,	F 0656		

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(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 0656 SS=D	Continued from page 46 stating in Assessment and plan section (part 5), "Bipolar disorder with psychotic features/confusion/anxiety: Continue current treatment per Medicine team. Patient currently managed on Lamotrigine 100 mg Q (every) 12H (hours), Aripiprazole 15 mg a day, Xanax 0.5 mg 3 times a day, and Sertraline 200 mg every day. Encouraged to follow up with Psych. Maintain fall and safety precautions. Continue supportive measures. Continue to reassure, redirect and reorient patient. Patient is at high risk for falls related to poor safety insight and judgment. Encouraged use of assistive devices. Encouraged activity and engagement. We will continue to monitor in conjunction with the nursing team and discuss any issues identified with Internal Medicine." Review of Resident R75's comprehensive care plan dated March 7, 2025, did not reveal a care plan for any behavioral health diagnoses of bipolar disorder or anxiety disorder. Interview with Assistant Director of Nursing,	F 0656		

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	395431	A. BLDG: 00 B. WING:	03/20/2025

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F 0656 SS=D	Continued from page 47 Employee E13 on March 20, 2025 at 9:45am, confirmed there was no care plan in place for behavioral health diagnoses of bipolar disorder or anxiety disorder. Review of Resident R97's comprehensive Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated February 6, 2025, revealed the resident was admitted to the facility on January 31, 2025, had moderate cognitive impairment, and diagnoses of non-Alzheimer's dementia and depression (mood disorder that causes a persistent feeling of sadness and loss of interest). Further review of Resident R97's MDS dated February 6, 2025, revealed the resident scored a "17" under section D "Mood" which can be interpreted as moderately severe depression. Review of Resident R97's clinical record revealed a psychiatry assessment dated March 10, 2025, by Psychiatric Mental Health Nurse Practitioner	F 0656		

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F 0656 SS=D	Continued from page 48 (PMHNP), Employee E8, that revealed Resident R97 expressed feeling anxious and depressed. Review of Resident R97's comprehensive care plan revealed no documented evidence a care plan was developed to address the diagnosis and care needs for a resident with a mood disorder. 28 Pa. Code 201.18(e)(1) Management 28 Pa Code 211.10(d) Resident care policies 28 Pa. Code 211.12 (c)(d)(1) Nursing Services	F 0656		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 49 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	1. Resident R-102's pain is being controlled as per physicians' orders 2. All residents who exhibit pain will be assessed to ensure that treatment and care in accordance with professional standards of practice occur. 3. Nurse Educator/Designee will re-educate the professional nursing staff on the policy, "Change in Resident Condition." 4. The DON/Designee will conduct weekly random audits times 2 months to ensure residents who have changes in their conditions receive treatment and care in accordance with professional standards of practice. 5. Audit results will be reviewed monthly by QAPI Committee.	Completion Date: **05/14/2025** Status: **APPROVED** Date: **04/14/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0684 SS=D	Continued from page 50 Based on staff interviews, and review of resident records determined the facility failed to document to ensure one resident (Resident R102) received treatment and care in accordance with professional standards of practice when the facility failed to properly assess and document a change of condition per physician orders for one of 31 records reviewed. (Resident R102) Findings include: Review of Resident R102's clinical record revealed that the resident was initially admitted to the facility on October 14, 2022, with the diagnoses of spastic quadriplegic cerebral palsy, major depressive and anxiety disorder, dysphagia (difficulty swallowing), and had a gastrostomy (a surgical tube place in the abdominal wall and into the stomach used to provide nutrients and medications when a person cannot eat or drink adequately). Review of Resident R102 quarterly MDS (an assessment of residents' needs) dated December	F 0684		

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F 0684 SS=D	Continued from page 51 29, 2024, indicated Resident R102 was completely dependent on staff for all activities of daily needs including bed mobility bathing and daily hygiene, with contractures to both sides of his upper and lower body. Review of Resident R102's care plan for chronic pain included interventions to assess for pain every shift for characteristics such as quality, severity, location, onset, duration, precipitating or relieving factors and to provide non-pharmacological relief such as repositioning. Review of Resident R102's physician orders instructed to assess for pain every day and night shift, indicate pain score (0 thru 10, 10 being the worst pain) provide nonpharmacological interventions document the interventions attempted. If no relief, provide medications as ordered, reassess within the hour of administration. Review of the electronic medication administration (EMAR) Licensed Practical Nurse Employee E15	F 0684		

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F 0684 SS=D	Continued from page 52 documented during the day shift on December 18, 2024, the resident was experiencing severe pain of 9/10. Further review of the clinical revealed no documented evidence nonpharmacological interventions were attempted, nor if medications was provided and/or reassessed within the hour for effectiveness. Continue review of the physician orders instructed to document every day and night shift if the resident is verbally crying out and to provide any additional documentation needed in progress notes. During day shift, on December 18, 2024, the same licensed nurse documented Resident R102 was verbally crying out. Further review of the resident's clinical record failed to provide any additional documentation as instructed by the physician. 28 Pa Code 211.10(c) Resident care policies 28 Pa. Code:211.12(d)(1)(5) Nursing services.	F 0684		

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F 0684 SS=D	Continued from page 53	F 0684		
F 0686 SS=D		F 0686		

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F 0686 SS=D	Continued from page 54 483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 0686	1. Resident R16 has an updated skin assessment that includes pressure ulcer location, stage, length, width, and depth measurements. 2. All newly admitted residents will have a skin assessment on admission that lists skin alterations to include location, stage, length, width, and depth measurements to ensure that pressure ulcer treatment is consistent with professional standards of practice. 3. Nurse educator/Designee will re-educate the professional nursing staff on the policy for pressure ulcer/skin assessment. 4. The DON/Designee will conduct weekly random audits times 2 months of residents with pressure ulcers and ensure proper documentation.	Completion Date: **05/14/2025** Status: **APPROVED** Date: **04/14/2025**

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F 0686 SS=D	Continued from page 55	F 0686	5. Audit results will be reviewed monthly by QAPI committee.	

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F 0686 SS=D	Continued from page 56 Based on review of facility policy, review of clinical record, and staff interview it was determined that the facility failed to provide pressure ulcer treatment, consistent with professional standards of practice, for one of three residents reviewed for pressure ulcers (Resident R18). Findings Include: Review of facility policy "Pressure Ulcers/Skin Breakdown" revised April 2018 revealed the nurse should describe and document/report a full assessment of the pressure ulcer including location, stage, length, width, and depth. The staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions. Review of Resident R18's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated February 18, 2025, revealed the resident had diagnoses of peripheral artery disease (narrowing of arteries which results in	F 0686		

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F 0686 SS=D	Continued from page 57 reduced blood flow to head, arms, stomach and legs), diabetes mellitus (metabolic disorder that affect how the body uses blood sugar), paraplegia (a form of paralysis that primary affects the lower part of the body), and stage four pressure ulcer (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) to the sacrum. Continued review of Resident R18's quarterly MDS revealed the resident was at risk for developing pressure ulcers and that the resident had a stage four pressure ulcer to the sacrum that was present on admission to the facility. Review of Resident R18's comprehensive care plan revised March 17, 2025, revealed the resident was at risk for and had actual skin breakdown to the sacrum (stage 4 pressure ulcer) and left lower extremity (stage 3 pressure ulcer - full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue). Interventions dated June 11, 2024, included to assess the wound for	F 0686		

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F 0686 SS=D	Continued from page 58 signs and symptoms of infection, increased drainage, or odor. Review of Resident R18's clinical record revealed the resident was hospitalized from February 19, 2025, through February 25, 2025, for an infection of the sacral pressure ulcer. Review of the hospital records revealed during Resident R18's hospital stay, the resident developed a new pressure ulcer on the left knee that received wound care. Further review of Resident R18's clinical record revealed a nursing admission/readmission evaluation dated February 25, 2025. Review of section c "skin integrity" within the nursing admission/readmission evaluation noted that Resident R18 had impaired skin integrity to the sacrum, left thigh (rear), and left ankle (outer). The assessment was incomplete as the sections to identify the type, stage, and measurements of the pressure ulcers was left blank. Review of Resident R18's clinical nursing notes and physician assessment revealed no documented	F 0686		

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F 0686 SS=D	Continued from page 59 evidence the wounds were assessed for the type of injury, the pressure ulcer stage, or a description of the pressure ulcers characteristics. Review of Resident R18's clinical record revealed the resident was re-hospitalized from March 1, 2025, through March 7, 2025. Review of R18's nursing admission/readmission evaluation, section c "skin integrity" dated March 7, 2025, noted that Resident R18 only had impaired skin integrity to the sacrum. The assessment was incomplete as the sections to identify the type, stage, and measurements of the pressure ulcers was left blank. Review of Resident R18's clinical nursing notes and physician assessment revealed no documented evidence the wounds were assessed for the type of injury, the pressure ulcer stage, or a description of the pressure ulcers characteristics. Review of Resident R18's clinical record revealed a	F 0686		

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F 0686 SS=D	Continued from page 60 wound note dated March 13, 2025, that indicated the resident had a stage 3 pressure ulcer of the left lower extremity and a stage 4 pressure ulcer of the sacrum. Interview on March 20, 2025, at 12:45 p.m. with the Assistant Director of Nursing, Employee E13, confirmed inaccurate/incomplete wound assessments. Assistant Director of Nursing, Employee E13, confirmed that there was no documented assessment of Resident R18's left lower extremity wound until March 13, 2025. Further interview confirmed Resident R18's nursing admission/readmission evaluation dated March 7, 2025, was inaccurate and did not include the skin impairment of the left lower extremity. 28 Pa. Code 211.12 (d)(5) Nursing services.	F 0686		

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F 0686 SS=D	Continued from page 61	F 0686		
F 0695 SS=D		F 0695		

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F 0695 SS=D	Continued from page 62 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	1. Resident R-115 has orders for Oxygen at 2/L min as needed for shortness of breath and will have Oxygen tubing dated and changed weekly when in use. Resident R-63 has Oxygen tubing dated correctly and changed weekly as per physician orders. 2. All residents with physician orders for supplemental Oxygen use will be assessed to ensure consistent respiratory care as per physician orders. 3. Nurse Educator/Designee will re-educate all professional nursing staff on the policy, "Oxygen Administration." 4. The DON/Designee will conduct random weekly audits times 2 months to ensure that residents who utilize supplemental Oxygen receive consistent respiratory care by	Completion Date: **05/14/2025** Status: **APPROVED** Date: **04/14/2025**

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F 0695 SS=D	Continued from page 63	F 0695	labeling and dating Oxygen tubing weekly as per physician orders. 5. Audit results will be reviewed monthly by QAPI Committee.	

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MAJESTIC OAKS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **558802**	**333 NEWTOWN ROAD WARMINSTER, PA 18974**

(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 0695 SS=D	Continued from page 64 Based on a review of clinical records and facility policies and procedures, observations of care and services, and interviews with staff, it was determined that the facility failed to consistently provide respiratory care and supplemental oxygen as ordered by the physician for two of 31 residents reviewed. (Resident R115 and R63). Findings included: A review of the facility policy titled "Oxygen Administration" dated October 2023, stated "The purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Review the resident's care plan to assess for any special needs of the resident". A review of a clinical record for Resident R115 revealed an admission on June 20, 2022, with a diagnosis of diffuse traumatic brain injury.	F 0695		

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F 0695 SS=D	Continued from page 65 A review of the physician order dated February 17, 2025, oxygen as needed to maintain O2 level above 92% at 2 Liter per min via nasal cannula, PRN for shortness of breath, every shift. A review of the physician order dated February 19, 2025, revealed "Oxygen Concentrator cleaning schedule 11-7 during weekly tubing change, remove filter on back wash with soap and water allow to dry and replace" one time a day every Wednesday. On March 17, 2025, at 12:06 p.m., it was observed that Resident R115 had oxygen set at 2.5 liters per minute via nasal cannula. The oxygen tubing was not labeled. Licensed nurse, Employee E5, confirmed these observations and reported that the setting should be 2 liters. She then adjusted the oxygen to 2 liters. Clinical record review revealed Resident R63 was admitted to the facility on September 1, 2024 with a diagnoses that included but not limited endocarditis (infection caused by bacteria that enter the blood stream and settle in the heart lining, a heart valve, or	F 0695		

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F 0695 SS=D	Continued from page 66 a blood vessel), acute and chronic respiratory failure (inability of lungs to exchange oxygen and carbon dioxide properly, causing insufficient oxygen in the blood), and muscle weakness. Review of Resident R63's physician orders, dated September 4, 2024, revealed an order for weekly oxygen tubing change. Observation on March 18, 2024 at 9:24 a.m. revealed Resident R63 had a label on her oxygen tubing dated February 27, 2025. Interview on March 18, 2025 at 9:28 a.m. with Licensed Practical Nurse, Employee E7, confirmed Resident R63's oxygen tubing had a date of February 27, 2025 and should be changed and dated weekly. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12 (d)(1)(5) Nursing services	F 0695		

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F 0695 SS=D	Continued from page 67	F 0695		
F 0700 SS=D		F 0700		

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F 0700 SS=D	Continued from page 68 483.25(n)(1)-(4) Bedrails §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by:	F 0700	1. R37 and R77 bedrails were tightened. They were also assessed for bedrails, physician order obtained, bed rails added to monitoring list 2. All residents with side rails will be assessed for appropriateness and safety. If appropriate order will be obtained from physician. Bed rails will be placed on and monitored. 3. Education to all department heads on process of adding and monitoring side rails 4. Random audits by the Administrator/designee of 5 residents with side rails to ensure that resident has assessment, order and that side rails are tight and have been added to maintenance monitoring list once a week for one	Completion Date: **05/14/2025** Status: **APPROVED** Date: **04/14/2025**

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F 0700 SS=D	Continued from page 69	F 0700	month. twice a week for one month and once a month for one month. The findings of the audits will be brought to the Quality monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

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F 0700 SS=D	Continued from page 70 Based on observation interview with resident and staff and review of clinical records and facility policy it was determined that the facility failed to appropriately assess residents for use of bedrails and failed to ensure correct installation, use and maintenance of bed rails were maintained for two of 31 resident records reviewed (Resident R37 and R77). Findings include: Review of Resident R37 medical diagnosis revealed the resident was admitted to the facility on January 10, 2025, identified lacking coordination, reduced mobility, abnormal posture and a need for assistance with personal care. Resident R37 was assessed as a fall risk and care planned to encourage the resident to use handrails/ siderails or assistive devices properly and to maintain the call bell within the resident's reach for preventing falls and accidents, dated January 10, 2025.	F 0700		

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F 0700 SS=D	Continued from page 71 During an interview on March 18, 2025, at 1:00 p.m. Resident R37 stated he did not like his bedrails and moved the bedrails to show how loose they were attached to his bed. During an interview on March 19. 2025 at 10:33 a.m., the Maintenance Director Employee E12 confirmed and stated Resident R37's bedrails were tightened because they were loose. The Maintenance Director also explained that he does not put bedrails on the beds without an order from the Director of Nursing or therapy. Interview with the Third floor Unit Manager, Registered Nurse Employee E11 on March 19, 2025, at 12:07 p.m. confirmed there were no physician orders for bedrails. "We need to request the assessment from therapy for bedrails and there isn't one." Review of Resident R77 medical diagnosis revealed the resident was admitted to the facility on	F 0700		

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F 0700 SS=D	Continued from page 72 November 27, 2024, identified with muscle weakness, difficulty with walking , a need for assistants with persons care and was a fall risk. On March 20, 2025 at 1:52 p.m. Resident R77 reported that her railings were very loose and she's not using them. The resident stated she didn't know why they were there because they don't help her get out of bed. Review of Resident R77 admission's assessment for bedrails dated November 27, 2024, indicated the resident was alert and oriented x3, did not use the side rails to achieve independence with bed mobility, was not assessed for entrapment risk from the side rails prior to their use, and did not request the side rails. Further review of Resident R77 clinical file revealed no physician orders allowing Resident R77's bed rails On March 20, 2025, at 1:26 p.m. the Director of	F 0700		

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F 0700 SS=D	Continued from page 73 Nursing was made aware of the above findings . 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 211.12 (d) (1)(3)(5) Nursing services. 28 Pa. Code 211.10(c)(d) Resident care policies.	F 0700		
F 0742 SS=D		F 0742		

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F 0742 SS=D	Continued from page 74 483.40(b)(1) Treatment/Srvcs Mental/Psychoscial Concerns §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by:	F 0742	1. Resident R-97 is now receiving Buspar 7.5mg BID as ordered. 2. All residents with Psychotropic medication recommendations will be reviewed to ensure treatment and services are received correctly to attain their highest practicable mental and psychosocial well-being. 3. Nurse Educator/Designee will re-educate the professional nursing staff on the policy, "Medication Orders." 4. The DON/Designee will conduct weekly random audits times 2 months to ensure that residents with recommendations for psychotropic medication changes are followed up timely with the physician. 5. Audit results will be reviewed monthly by QAPI Committee.	Completion Date: **05/14/2025** Status: **APPROVED** Date: **04/14/2025**

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F 0742 SS=D	Continued from page 75 The facility failed to ensure that one resident, who displayed mental disorder or psychosocial adjustment difficulty, received treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being for one of four residents reviewed for mood/behavior (Resident R97). Findings Include: Review of Resident R97's comprehensive Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated February 6, 2025, revealed the resident was admitted to the facility on January 31, 2025, had moderate cognitive impairment, and diagnoses of non-Alzheimer's dementia and depression. Further review of Resident R97's MDS dated February 6, 2025, revealed the resident scored a "17" under section D "Mood" which can be interpreted as moderately severe depression.	F 0742		

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F 0742 SS=D	Continued from page 76 Review of Resident R97's clinical record revealed a psychiatry assessment dated March 10, 2025, by Psychiatric Mental Health Nurse Practitioner (PMHNP), Employee E8, that revealed Resident R97 expressed feeling anxious and depressed. Staff reported resident showed intermittent behavioral disturbances such as agitation and restlessness. Further review of the psychiatry assessment dated March 10, 2025, revealed PMHNP, Employee E8, recommended to start Resident R97 on Buspar (anti-anxiety medication) 7.5 milligrams (mg) two times per day to support anxiety. Review of Resident R97's clinical record revealed a follow-up psychiatry assessment dated March 17, 2025, by Psychiatric Mental Health Nurse Practitioner, Employee E8, which indicated Resident R97 reported feeing sad about the state of the world and having visual hallucinations. Further review of the psychiatric assessment dated March 17, 2025, PMHNP, Employee E8, indicated	F 0742		

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F 0742 SS=D	Continued from page 77 staff had not started Resident R97 on Buspar as recommended at the last visit on March 10, 2025, to support anxiety. Review of Resident R97's clinical record revealed no documented evidence the facility implemented the Buspar as the Psychiatric Mental Health Nurse Practitioner, Employee E8, recommended. Interview on March 19, 2025, at 1:20 p.m. with Registered Nurse, Employee E9, confirmed the facility did not implement the medication as recommended. 28 Pa. Code 211.12 (d)(5) Nursing Services	F 0742		
F 0755 SS=D		F 0755		

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F 0755 SS=D	Continued from page 78 483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 0755	1. Resident R-116 has Ativan 0.5mg available as needed for Anxiety. 2. All residents with new orders for PRN Ativan will be assessed to ensure timely acquisition and administration of prescribed medications. 3. Nurse Educator/Designee will re-educate all professional nursing staff on the policy, "Medication Orders." 4. The DON/Designee will conduct random weekly audits times 2 months to ensure residents who have new orders for PRN Ativan have the medication delivered timely from the pharmacy. 5. Audit results will be reviewed monthly by QAPI committee.	Completion Date: **05/14/2025** Status: **APPROVED** Date: **04/14/2025**

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F 0755 SS=D	Continued from page 79 This REQUIREMENT is not met as evidenced by:	F 0755		

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F 0755 SS=D	Continued from page 80 Based on review of clinical records, facility policy, and staff and resident interviews, it was determined that the facility failed to ensure the timely acquisition and administration of a prescribed medication to meet the needs of one of 31 residents reviewed (Resident R16). Findings include: A review of Resident 16's clinical record revealed Resident R16 was admitted to the facility September 1, 2022 , with diagnoses that included but not limited to congestive heart failure (condition that happens when your heart can't pump blood well enough you meet the body's needs), alcoholic polyneuropathy (damage to the nerves caused by excessive alcohol consumption), and generalized anxiety disorder. On March 18, 2025 at 12:10 p.m. interview with Resident R16 revealed Resident R16 was experiencing anxiety due to a recent event that occurred in his personal life. Resident R16 stated	F 0755		

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(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 0755 SS=D	Continued from page 81 the physician ordered Ativan and he did not receive it for 3 days due to the medication not being available. Review of Resident R16's nursing progress note, dated February 11, 2025 at 1:25 p.m., revealed resident is able to express his emotions; grief and informed this nurse he will be dealing with a lot of anxiety over the next few days. Physician notified and Ativan 0.5 mlligrams (mg) by mouth twice a day was ordered. Order placed in residents record and pharmacy notified to contact physician for script. Review of physician's orders, dated March 12 2025, revealed the physician prescribed Ativan 0.5 mg to be given by mouth twice a day for 3 days. Review of Resident R16's MAR (medication administration record) revealed Ativan 0.5 mg was given on March 14, 2025 at 1:08 p.m. On March 19, 2025 at 10:30 a.m. interview with Employee E10, Registered Nurse, stated the	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395431	A. BLDG: __00_____ B. WING: _____	03/20/2025

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F 0755 SS=D	Continued from page 82 pharmacy did not approve the script in a timely manner and that is why there was a delay is Resident R16 receiving his medication. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services 28 Pa. Code 211.9 (f)(2) Pharmacy services	F 0755		
F 0804 SS=E		F 0804		

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F 0804 SS=E	Continued from page 83 483.60(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. Cooks were educated on proper cooking methods for chicken. Residents who did not like their meal were offered alternative. 2. Food Committee will discuss concerns with any other foods. Education to Cooks to ensure that they are cooking meals the appropriate way. 3. Education to staff that if residents are not happy with a meal to alert administration and offer an alternative. 4. Random audits by the Administrator/designee of 5 residents to ensure that they are happy with their meal and that it was nutritious, appeared nice, palatable, and at preferred temperature once a week for one month. twice a week for one month and once a	Completion Date: **05/14/2025** Status: **APPROVED** Date: **04/14/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0804 SS=E	Continued from page 84	F 0804	month for one month. The findings of the audits will be brought to the Quality monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0804 SS=E	Continued from page 85 Based on observations during dining and resident interviews it was determined that the facility failed to serve food that was palatable and attractive to meet resident needs for 20 of 20 residents reviewed (Resident R62, R13, R35, R129, R70, R49, R6, R4, R96, R92, R93, R30, R9, R120, R122, R81, R108, R83, R58, and R139). Findings Include: During a Resident Council meeting on March 18, 2025, at 10:30 a.m. with 11 alert and oriented residents (R62, R13, R35, R129, R70, R49, R6, R4, R96, R92, R93) residents reported that the chicken being served is dry. Review of the facility menu revealed chicken was on the menu for lunch on March 18, 2025. Observations on March 18, 2025, at approximately 12:30 p.m. on the 2nd floor nursing unit during the lunch time meal revealed the following: Observations and interview at 12:38 p.m. revealed	F 0804		

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F 0804 SS=E	Continued from page 86 Resident R30 refused to eat the chicken served for lunch because it was dry. Observations and interview at 12:50 p.m. revealed Resident R9 and R120 refused to eat the chicken because it was served cold. Observations and interview at 12:51 p.m. revealed Resident R122 refused to eat the chicken because it was served dry. Observations at 12:53 p.m. revealed Resident R81 was being fed lunch by nurse aide, Employee E16. Interview with nurse aide, Employee E16, reported Resident R81 spit the chicken out and refused to eat it. Interview at 12:55 p.m. with alert and oriented Resident R108 revealed the chicken was "hard as a rock" and that the resident could not finish eating it. Interview at 12:56 p.m. with alert and oriented Resident R83 revealed the chicken was served dry.	F 0804		

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F 0804 SS=E	Continued from page 87 Observations and interview at 12:57 p.m. revealed Resident R92 had an un-eaten thin, overcooked piece of chicken on her plate. Resident R92 reported being unable to cut the chicken and subsequently not being able to eat it. Interview at 12:58 p.m. with alert and oriented Residents R58 and R139 revealed the chicken was served very dry and was inedible. 28 Pa. Code 211.10(c) Resident care policies	F 0804		
F 0806 SS=D		F 0806		

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F 0806 SS=D	Continued from page 88 483.60(d)(4)(5) Resident Allergies, Preferences, Substitutes §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by:	F 0806	1. R97 and R6 were provided with a meal that was in house and met allergies, preference. Hamburgers and hotdogs were taken off the always available menu. Dietitian met with resident R6 to ensure that we have allergies noted and address her restrictions. 2. Always available menu will be adjusted if item is unable to be delivered. Audit to ensure that all residents have dietary restrictions and preferences in place. 3. Education provided to Dietician, and Food Service Employees to ensure that preference, restrictions and allergies are being followed. Education that if a item that is on the always available menu is not able to be kept in stock it must be removed.	Completion Date: **05/14/2025** Status: **APPROVED** Date: **04/14/2025**

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F 0806 SS=D	Continued from page 89	F 0806	4. Random audits by the Administrator/designee of 5 residents to ensure that residents are receiving a meal that meets their needs related to allergens, preferences and restrictions once a week for one month. twice a week for one month and once a month for one month. Random audits of the Always available menu to ensure food is available once a week for one month. twice a week for one month and once a month for one month. The findings of the audits will be brought to the monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with the coordination of the interdisciplinary team at QAPI Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0806 SS=D	Continued from page 90 Based on observations and staff and resident interviews it was determined that the facility failed to provide a substitute for a resident who requested a meal alternative and failed to serve foods that accommodate a residents allergies for two of 26 residents reviewed during dining (Resident R97 and R6). Findings Include: Review of Resident R97's comprehensive Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated February 6, 2025, revealed the resident was admitted to the facility on January 31, 2025, had moderate cognitive impairment, and had a diagnosis of malnutrition (deficiencies, excesses, or imbalances in a person's intake of energy and/or nutrients). Observations on March 17, 2025, revealed an "always available menu" dated February 18, 2025, posted on the wall on the 2nd floor nursing unit located next to the elevators. For the lunch and	F 0806		

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F 0806 SS=D	Continued from page 91 dinner meal, a hamburger was listed as an alternative option that could be requested by calling the kitchen. Observations on March 17, 2025, at 1:15 p.m. revealed Resident R97 did not eat his lunch. Resident R97 stated he wasn't in the mood for what was served and subsequently requested a hamburger. During an interview on March 17, 2025, with Unit Clerk, Employee E17, the surveyor informed the employee that Resident R97 requested a hamburger for lunch. Unit Clerk, Employee E17, called the kitchen to request a hamburger for Resident R97. Unit Clerk, Employee E17, reported that the kitchen stated they could not make a hamburger for Resident R97 and to let the resident know hamburgers would be on the menu the next day. Clinical record review revealed Resident R6 was admitted to the facility November 21, 2023 with a diagnosis that included but not limited to multiple	F 0806		

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F 0806 SS=D	Continued from page 92 sclerosis (disease that causes breakdown of the protective covering of nerves), chronic obstructive pulmonary disease (airway disease that restricts breathing), and muscle weakness. Review of Resident R6's dietary orders, dated February 7, 2025, revealed a lactose restricted diet. Review of Resident R6's care plan, dated November 27, 2023, revealed resident has a nutritional problem or potential nutritional problem related to lactose and tolerance, requiring a therapeutic diet. Intervention included providing Resident R6 with a lactose restricted diet. Interview on March 18, 2025 at 9:30 a.m. with Resident R6 revealed she does not receive a lactose diet. Resident R6 further stated her meals include cheese and milk, which causes her to have loose bowel movements. Observation on March 19, 2025 at 12:05 p.m. revealed Resident R6 was served cheese on top of	F 0806		

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F 0806 SS=D	Continued from page 93 chicken. 28 Pa. Code 201.18(b)(3) Management 28 Pa Code 211.6(a) Dietary services	F 0806		
F 0812 SS=F		F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0812 SS=F	Continued from page 94 483.60(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	1. Tortillas unwrapped with no dates were immediately discarded. Two juice bags that were placed on dirty shelf were discarded and rack cleaned. The juice tubbing that was not hooked up was cleaned and wrapped in plastic till replaced with another one. The drainpipe behind ice machine was placed directly into the floor drain with no air gap was Immediately fixed. 2. All other areas rounded to ensure no further concerns. 3. Education provided to Dietary Staff on properly storing food, dating food, properly storing juice bags, ensuring racks are cleaned, what to do if juice runs out and there is not another to replace and that there	Completion Date: **05/14/2025** Status: **APPROVED** Date: **04/14/2025**

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F 0812 SS=F	Continued from page 95	F 0812	must be an air gap between ice machine and drain access. 4. Random audits by the Administrator/designee to ensure food is properly stored, dated, juice bags being stored properly, racks cleaned, juice tubbing that is not hooked up maintained properly, and that there is a air gap between ice machine and drain once a week for one month. twice a week for one month and once a month for one month. The findings of the audits will be brought to the monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

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F 0812 SS=F	Continued from page 96 Based on observations in the main kitchen and staff interview it was determined that the facility failed to ensure that food was stored, prepared, and served in accordance with professional standards for food service safety. Findings include: A tour of the Food Service Department conducted on March 17, 2025, at 9:22 a.m. with Employee E5, Food Service Director, revealed the following concerns: Observations of the walk-in freezer revealed two tortillas loosely wrapped in plastic wrap with no dates. Observations of the dry storage room revealed the juices used for the juice machine were stored in this room. Two juice bags (fruit punch and orange juice) were taken out of the box and placed directly on a visibly dirty/dusty metal wrack.	F 0812		

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F 0812 SS=F	Continued from page 97 One juice was not hooked up (cranberry juice) and the tubing was on the floor and backed up with stagnant juice in the tubing. Observations revealed the drainpipe behind the ice machine was placed directly into the floor drain with no air gap. To prevent sewer water backup, all ice machine drains require an air gap of a few inches between the ice machine ' s drain point and the facility's drain access point. Observations were confirmed by the Food Service Director, Employee E5, throughout the duration of the kitchen tour. 201.14 (a) Responsibility of licensee.	F 0812		
F 0814 SS=F		F 0814		

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F 0814 SS=F	Continued from page 98 483.60(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. Trash was cleaned up and lid closed. 2. All other areas checked to ensure no other areas that trash was disposed of improperly. 3. Education provided to all kitchen, Housekeeping and Department Heads that trash must be in he dumpster, depress swept up and lid closed. 4. Random audits by the Administrator/designee of dumpster area to ensure proper disposal of garbage and lid down once a week for one month. twice a week for one month and once a month for one month. The findings of the audits will be brought to the Quality monthly Quality Assurance Improvement Committee (QAPI) meeting monthly	Completion Date: **05/14/2025** Status: **APPROVED** Date: **04/14/2025**

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F 0814 SS=F	Continued from page 99	F 0814	for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

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F 0814 SS=F	Continued from page 100 Based on observations and interviews with staff, it was determined that the facility did not ensure that that trash was properly disposed of in the receiving and dumpster area. Findings Include: A tour of the main kitchen was conducted on March 17, 2025, at 9:22 a.m. with the Food Service Director, Employee E5. Observations revealed double doors adjacent to the main kitchen where food deliveries are accepted and lead out to where the dumpsters are stored. Observations in the receiving area outside revealed trash, food, and debris on the ground surrounding the dumpsters. On one dumpster, the lid was open, and trash was exposed. 28 PA Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(3) Management	F 0814		

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F 0880 SS=E		F 0880		

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F 0880 SS=E	Continued from page 102 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	1. Resident R-102 continues with enhanced barrier precautions. Employees E-13 and E-14 have been re-educated on Enhanced Barrier Precautions. 2. All residents who require Enhanced Barrier Precautions will be identified and protective equipment made available for staff with appropriate identification signs to ensure proper use of PPE for residents on Enhanced Barrier Precautions to ensure infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms to residents. 3. Nurse Educator/Designee will re-educate staff on the policy, Enhanced Barrier Precautions." 4. The DON/Designee will conduct weekly random audits times 2 months to ensure that staff is	Completion Date: **05/14/2025** Status: **APPROVED** Date: **04/14/2025**

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F 0880 SS=E	Continued from page 103 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	utilizing the proper PPE in the rooms of residents identified requiring Enhanced Barrier Precautions. 5. Audit results will be reviewed monthly by QAPI Committee.	

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F 0880 SS=E	Continued from page 104	F 0880		

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F 0880 SS=E	Continued from page 105 Based on review of facility protocol, observations, interview ,and review of clinical records, it was determined that the facility failed to implement proper use of personal protective equipment (PPE) for one resident on enhanced barrier precautions during morning care and wound observation of 31 resident records reviewed (Resident R102). Findings include: Review of the facility policy for "Enhanced Barrier Precautions" (EBP) revised December 2024 states it is used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms to residents. EBP employ targeted gown and glove use during high contact resident care activates EBP are indicated for residents with wounds and or indwelling medication devices. Resident R102 was initially admitted to the facility on October 14, 2022, diagnosed with spastic quadriplegic cerebral palsy, major depressive and	F 0880		

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F 0880 SS=E	Continued from page 106 anxiety disorder, dysphagia (difficulty swallowing) , and had a gastrostomy (a surgical tube place in the abdominal wall and into the stomach used to provide nutrients and medications when a person cannot eat or drink adequately). Resident R102's had orders to use EBP and was care planned for use while maintaining tube feedings, incontinence care and wound care. On March 17, 2025, at 10:00 a.m. it was observed nursing assistant Employee E14, aide was providing incontinence care without the use of EBP. On March 18, 2025, at 11:30 a. m. during wound observation Unit manager Employee E12 provided care without the use of EBP. On March 18, 2025, at 3:36 p.m. the Assistant Director of Nursing Employee E13 was made aware and confirmed EBP use with care. 28 Pa. Code 211.12(d)(1) Nursing services	F 0880		

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F 0880 SS=E	Continued from page 107 28 Pa. Code 211.12(d)(5) Nursing services	F 0880		
F 0919 SS=D		F 0919		

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F 0919 SS=D	Continued from page 108 483.90(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. Residents R-37, R-115, R-153, R-109, and R-88 have their call bells with-in their reach. 2. The facility will assess all residents to ensure that they have their call bell with-in their reach to ensure timely responses to their requests and needs. 3. Nurse Educator/Designee will re-educate all staff on the policy, "Answering Call light." 4. The DON/Designee will conduct weekly random audits times 2 months to ensure residents call bells are with-in their reach. 5. Audit results will be reviewed monthly by QAPI Committee.	Completion Date: **05/14/2025** Status: **APPROVED** Date: **04/14/2025**

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F 0919 SS=D	Continued from page 109 Based on observations, interviews with staff and residents and review of facility policy, it was determined that the facility failed to ensure that call bells were within reach for five of 31 residents reviewed. (Resident R37, R115, R153, 109, R88). Findings include: A review of the policy titled " Answering Call light" last revised March 2021 revealed " The purpose of this procedure is to ensure timely responses to the resident's requests and needs". Its further states under General Guideline bulletin 4. "Be sure that the call light is plugged in and always functioning. 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident". Review of Resident R37's medical diagnosis revealed the resident was admitted to the facility on January 10, 2025, identified lacking coordination, reduced mobility, abnormal posture and a need for	F 0919		

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F 0919 SS=D	Continued from page 110 assistance with personal care. Resident R37 was assessed as a fall risk and care planned to encourage the resident to use handrails/ siderails or assistive devices properly and to maintain the call bell within the resident's reach for preventing falls and accidents, dated January 10, 2025. During an interview on March 18, 2025, at 1:00 p.m. Resident R37 was observed sitting in his wheelchair and the resident's call bell was out of reach found on the floor on the opposite side of the bed. The resident indicated his call bell was broke for a while until it was fixed. On March 19, 2025, at 10:33 p.m. with Resident R37, the Maintenance Director explained the call bell was never broken it was because nursing ties the cord around the bed. "If someone moves the bed it pulls the cord out of the wall and it falls to the floor. No one uses the clips that are all attached to the call bell cord that can be attached to the bed	F 0919		

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F 0919 SS=D	Continued from page 111 covers." It was observed that during this time the maintenance director indicated Resident R37's call bell was not in the resident's reach and further found that the roommates call bell was clipped to the resident's curtain, also not in reach. A review of a clinical record for Resident R115 revealed an admission on June 20, 2022, with a diagnosis of diffuse traumatic brain injury, adult failure to thrive, difficult in walking, muscle weakness, need for assistance with personal care, and history of falling. On March 17, 2025, at 12:14 p.m., an interview was held with Resident R115 who asked to raise his bed to a sitting position. Surveyor asked for Resident R115 to press the call bell, and it revealed that his call bell was stuck in his bedside drawer, and he was not able to reach his call bell. The surveyor pressed the call bell in room 409, but there was no response from any staff. The surveyor then went to the 4th-floor nursing station, where it	F 0919		

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F 0919 SS=D	Continued from page 112 was discovered that the call bell panel was sitting on the nursing desk, completely turned off and unplugged from the outlet. Licensed nurse, Employee E5 was sitting at the nursing station. When asked how staff could respond to the call bell, Employee E5 confirmed that the call bell system had not been turned on, which is why she was unable to see which call bell needed to be answered. Employee E5 then plugged the call bell panel into the outlet, and it was revealed that the call bell for room 409 had been actively ringing for 16 minutes. During this same interview when Employee E5 came to the room and she confirmed that Resident R115's call bell was out of reach and was stuck in his bedside drawer. She assisted the resident and clipped the call bell to his bed sheets. On March 17, 2025, at 12:28 p.m. a tour on the unit with license nurse, Employee E5 revealed that Resident R109 had her call bell in front of her bed which was not reachable to the resident and Resident R153 was also not in reachable position of the call bell. It was further confirmed that both	F 0919		

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F 0919 SS=D	Continued from page 113 Resident's R153 and R109 are confined to their bed and require assistance with personal care. On March 17, 2025, at 1:44 p.m. a tour was conducted with the unit manager, Employee E3 who confirmed that the call bell in room 426's restroom was not attached to the wall. During a Resident Council meeting on March 18, 2025, at 10:30 a.m., 11 residents (R62, R13, R35, R129, R70, R49, R6, R4, R96, R92, R93), all of whom were alert and oriented, reported that when they pressed the call bell, facility staff would enter the room and turn off the bell without providing assistance. They were often told, "I'm not assigned to you, I'll let your staff know," but no one would return to help. On March 19, 2025, at 9:52 a.m., a tour was conducted with the Director of Social Services, Employee E4, on the 4th-floor nursing unit. During the tour, it was observed that the call bell panel was showing an active call bell in room 424-B for 42 minutes. Upon arriving in room 424-B, Resident	F 0919		

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F 0919 SS=D	Continued from page 114 R88 was in bed and reported that they had pressed the call bell to request a change. Although Resident R88 had already been changed by a nursing aide, the call bell was still active and would not turn off. Employee E4 reported the malfunctioning call bell to maintenance. On March 19, 2025, at approximately 10:30 a.m., the Maintenance Director, Employee E6, confirmed that the call bell in room 424-B was broken and that the entire call bell panel needed to be replaced. 28 Pa. Code 211.12(d)(1(5) Nursing services	F 0919		
F 0925 SS=F		F 0925		

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F 0925 SS=F	Continued from page 115 483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by:	F 0925	1. Door sweep was immediately fixed. Will be replacing the double doors next to the dumpster. Date pending. Plastic Dolly was immediately sanitized. 2. Reviewed last 3 months of pest control reports to ensure nothing else has not been followed up on. 3. Education provided to Maintenance Dept that all recommendation must be reviewed and followed up on timely Education provided to all staff that if any item has any types of dropping to notify maintenance and mgt immediately, remove item to be sanitized. 4. Random audits by the	Completion Date: **05/14/2025** Status: **APPROVED** Date: **04/14/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395431	A. BLDG: __00_____ B. WING: _____	03/20/2025

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F 0925 SS=F	Continued from page 116	F 0925	Administrator/designee to ensure that pest control reports are followed up on timely. once a week for one month. twice a week for one month and once a month for one month. Random audits by Administrator / designee to ensure that no items or places have been seen with mouse droppings. The findings of the audits will be brought to the Quality monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0925 SS=F	Continued from page 117 Based on observations, review of facility documentation, and staff interviews it was determined that the facility failed to establish an effective pest control program in the main kitchen. Findings Include: Review of pest control report dated March 4, 2025, revealed pest control inspected and treated the kitchen areas, storage areas, and dishwasher room for occasional invaders. Per the pest control report, mice droppings were observed in the kitchen food storage room. Pest control recommended a door sweep in the kitchen doors and replacing doors to the small room outside, next to the dumpster, as te doors are rotten. A tour of the main kitchen was conducted on March 17, 2025, at 9:22 a.m. with the Food Service Director, Employee E5. Observations revealed double doors adjacent to the main kitchen where food deliveries are accepted and lead out to where the dumpsters are stored. There was a visible gap	F 0925		

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F 0925 SS=F	Continued from page 118 located at the bottom of the door allowing easy access to the main kitchen for common household pests (mice, roaches, flies, ants). Observations on March 19, 2025, at 12:15 p.m. in the main kitchen revealed a significant amount of mouse droppings on top of an empty plastic rack dolly (designed for transporting dish racks) that was placed directly outside the entry for the dish room amongst the other plastic rack dolly used to store clean dishes. Observations of the mouse droppings were confirmed by the Food Service Director, Employee E5. Further observations on March 19, 2025, at 1:55 p.m. with the Food Service Director, Employee E5, revealed the facility did not follow through on recommendations made from pest control company and the small room next to the dumpsters still had rotten/broken doors with large holes at the bottom of the doors. 28 Pa. Code 201.14 (a) Responsibility of licensee.	F 0925		

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F 0925 SS=F	Continued from page 119	F 0925		

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P 4860		P 4860		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 4860	Continued from page 1 Medical records. (d) Records of discharged residents shall be completed within 30 days of discharge. Medical information pertaining to a resident ' s stay shall be centralized in the resident ' s record. This REGULATION is not met as evidenced by:	P 4860	1. R164 is discharged and record closed. R162 is discharged and record closed. 2. All discharges from March 20 will be audited to ensure 30 day discharge note from attending physician has been completed. 3. Education to all attendings that a discharge summary must be completed within 30 days completed. 4. Random audits by the Administrator/designee of up to 5 residents to ensure that the attending has completed a 30 days discharge note once a week for one month. twice a week for one month and once a month for one month. The findings of the audits will be	Completion Date: **05/14/2025** Status: **APPROVED** Date: **04/14/2025**

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P 4860	Continued from page 2	P 4860	brought to the monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

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P 4860	Continued from page 3 Based on review of closed clinical records, facility policy and interview with facility staff, it was determined that the facility failed to complete a discharge summary within the required 30 days of discharge for two of three residents reviewed upon discharge. (R162, R164). Findings include: A review of the facility policy titled "Transfer or discharge Documentation" revised, December 2016 noted under bulletin 5. " Should the resident be transferred or discharged for any of the following reasons, the basis for the transfer or discharge will be documented in the resident's clinical record by the resident's Attending Physician". Review of Resident R164's clinical record revealed that the resident was admitted to the facility on December 9, 2024, and discharged on December 18, 2024. Review of the closed clinical record of Resident R164 revealed that the facility failed to complete a discharge summary within the required	P 4860		

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P 4860	Continued from page 4 30 days of discharge. An interview with the facility Nursing Home Administrator, Employee E1 on March 20, 2025, at 11:56 p.m. confirmed this finding. Review of Resident R162's clinical record revealed that the resident was admitted to the facility on November 26, 2013 and discharge to the hospital on January 13, 2025. Review of Resident 162's closed clinical record revealed that the facility failed to complete a discharge summary within the required 30 days of discharge. An interview with the facility Nursing Home Administrator, Employee E1 on March 20, 2025 at 10:20am, confirmed no documented evidence of discharge summary completed.	P 4860		
P 5520		P 5520		

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P 5520	Continued from page 5 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	1. Administrator, Director of Nursing, Staffing Coordinator and/or Designee will continue to recruit and advertise to satisfy the staffing regulation to ensure that quality of care is provided to the residents. This will be done by rounding, observation, auditing, communication with residents and families through daily interaction, care conferences and resident council. 2. Staffing for the facility was reviewed to ensure that the center is meeting and adhering to ensure that the facility had adequate resident to nurse aide (NA) ratio to meet the regulatory requirement Effective July 1, 2024 of 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. 3.	Completion Date: **05/14/2025** Status: **APPROVED** Date: **04/14/2025**

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P 5520	Continued from page 6	P 5520	Education regarding the nurse aide ratio of 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 was provided to the staffing coordinator, HR, nursing administration to ensure that the center is in compliance. 4. A weekly audit of nurse aide ratio staffing will be conducted by the NHA/designee to ensure that the facility meets regulatory requirements. The findings of the audits will be brought to the Quality monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

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P 5520	Continued from page 7 Based on a review of nursing staffing hours and staff interview, it was determined that the facility did not ensure a minimum of one nurse aid (NA) for every 12 residents on the day shift for 2 of 21 days reviewed, one NA for every 12 residents on the evening shift for 3 of 21 days reviewed, and one NA for every 20 residents during the night shift on 4 of 21 days reviewed. Findings include: Review of nursing staff care hours provided by the facility revealed the following staff scheduled for the resident census: Day shift (requires one NA per 12 residents) December 30.2024, 14 NAs, with a census of 147 residents, required 14.7 NAs. March 17, 2025, 15.37 Nas, with a census of 158 residents, required 15.80 Nas. Evening shift (requires one NA per 12 residents) December 29, 2024, 12.93 NAs with a census of 147 residents required 13.36 NAs. December 31, 2024, 13.00 NAs with a census of 150 residents required 13.64 NAs. January 1, 2025, 13.53 Nas with a census of 151 residents required 13.73 NAs.	P 5520		

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P 5520	Continued from page 8 Night shift (requires one NA per 20 residents) October 8, 2024, 9.07 NAs, with a census of 159 residents, required 10.60 NAs. October 9, 2024, 10.07 NAs, with a census of 158 residents, required 10.53 NAs. March 13, 2025, 9.53 NAs, with a census of 159 residents, required 10.60 NAs. March 18, 2025, 9.57 NAs, with a census of 159 residents, required 10.60 NAs. Interview with the Nursing Home Administrator on March 20, 2025, at 11:00 a.m. confirmed that the above staffing did not meeting the required minimums.	P 5520		
P 5530		P 5530		

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P 5530	Continued from page 9 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	1. Administrator, Director of Nursing, Staffing Coordinator and/or Designee will continue to recruit and advertise to satisfy the staffing regulation to ensure that quality of care is provided to the residents. This will be done by rounding, observation, auditing, communication with residents and families through daily interaction, care conferences and resident council. 2. Staffing for the facility was reviewed to ensure that the center is meeting and adhering to ensure that the facility had adequate resident to LPN ratio to meet the regulatory requirement 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. 3. Education regarding the LPN ratio of a minimum of 1 LPN per 25 residents	Completion Date: **05/14/2025** Status: **APPROVED** Date: **04/14/2025**

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P 5530	Continued from page 10	P 5530	during the day, 1 LPN per 30 residents during the evening and 1 LPN per 40 residents overnight was provided to the staffing coordinator, HR, nursing administration to ensure that the center is in compliance. 4. A weekly audit of nurse aide ratio staffing will be conducted by the NHA/designee to ensure that the facility meets regulatory requirements. The findings of the audits will be brought to the Quality monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

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P 5530	Continued from page 11 Based on a review of nursing staffing hours and staff interview, it was determined that the facility did not ensure a minimum of one Licensed Nurse (LPN) for every 25 residents on the day shift for one of 21 days reviewed. . Findings include: Review of nursing staff care hours provided by the facility revealed the following staff scheduled for the resident census: Day shift (requires one LPN per 25 residents) March 19, 2025 5.00 LPNs, with a census of 158 residents, required 6.32 LPNs. Interview with the Nursing Home Administrator confrimed on March 20, 2025 at 11:00 a.m. the above staffing levels did not meet the required minimums.	P 5530		
P 5640		P 5640		

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P 5640	Continued from page 12 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	1. Administrator, Director of Nursing, Staffing Coordinator and/or Designee will continue to recruit and advertise to satisfy the staffing regulation to ensure that quality of care is provided to the residents. This will be done by rounding, observation, auditing, communication with residents and families through daily interaction, care conferences and resident council. 2. Staffing for the facility was reviewed to ensure that the center is meeting and adhering to meet the regulatory requirement 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 min of 3.2 hours of direct resident care for each resident. 3. Re education regarding that the total	Completion Date: **05/14/2025** Status: **APPROVED** Date: **04/14/2025**

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MAJESTIC OAKS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **558802**	**333 NEWTOWN ROAD WARMINSTER, PA 18974**

(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
P 5640	Continued from page 13	P 5640	minimum number of direct resident care hours 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 min of 3.2 hours of direct resident care for each resident. was provided to the staffing coordinator, HR, nursing administration to ensure that the center is in compliance. 4. A weekly audit of direct care hours will be conducted by the NHA/designee to ensure that the facility meets regulatory requirements. The findings of the audits will be brought to the Quality monthly Quality Assurance Improvement Committee (QAPI) meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395431	A. BLDG: 00 B. WING:	03/20/2025

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P 5640	Continued from page 14 Based on a review of nursing staffing hours and staff interview, it was determined that the facility did not ensure a minimum of 3.20 nursing care hours per patient, per day, for 18 of 21 days reviewed (October 3, 2025:-October 9, 2024, December 27, 2024 -January 2, 2025, and March 13. 2025-March 19, 2025) Findings include: Review of nursing staff care hours provided by the facility revealed the following staff scheduled for the resident census: October 3, 2024, 481.00 care hours with a census of 155 residents, totaling 3.10 PPD. October 4, 2024, 495.00 care hours with a census of 157 residents, totaling 3.15 PPD. October 7, 2024, 464.00 care hours with a census of 156 residents, totaling 2.97 PPD. October 8, 2024, 485.75 care hours with a census of 159 residents, totaling 3.06 PPD. October 9, 2024, 480.00 care hours with a census of 158 residents, totaling 3.04 PPD. December 27. 2024. 461.00 care hours with a census of 150	P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640	Continued from page 15 residents, totaling 3.08 PPD. December 28, 2024. 437.50 care hours with a census of 147 residents, totaling 2.98 PPD. December 29, 2024, 462.50 care hours with a census of 149 residents, totaling 3.10 PPD. December 30. 2024. 450.53 care hours with a census of 147 residents, totaling 3.06 PPD. December 31. 2024. 430.75 care hours with a census of 150 residents, totaling 2.87 PPD. January 1, 2025, 454.75 care hours with a census of 151 residents, totaling 3.01 PPD. January 2, 2025, 341.25 care hours with a census of 150 residents, totaling 2.28 PPD. March 13, 2025, 487.25 care hours with a census of 159 residents, totaling 3.07 PPD. March 14, 2025, 491.00 care hours with a census of 157 residents, totaling 3.13 PPD. March 16, 2025, 488.00p care hours with a census of 158 residents, totaling 3.09 PPD.	P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640	Continued from page 16 March 17, 2025, 473.25 care hours with a census of 158 residents, totaling 3.00 PPD. March 18, 2025, 477.50 care hours with a census of 159 residents, totaling 3.00 PPD. March 19, 2025, 466.00 care hours with a census of 158 residents, totaling 2.95 PPD. Interview with the Nursing Home Administrator on March 20, 2025, at 11:00 a.m. confirmed that the above staffing levels did not meet the required minimums.	P 5640		

Certified End Page

MAJESTIC OAKS REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 558802

SURVEY EXIT DATE: 03/20/2025

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
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