STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD** **NEWTOWN, PA 18940**

(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, Civil Rights Compliance Survey, and State Licensure Survey, completed on December 05, 2024, it was determined that Pennswood Village, was not in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations related to the health portion of the survey process.	F 0000		
F 0684 SS=J		F 0684		

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940**

(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 0684 SS=J	Continued from page 1 483.25 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	Facility will immediately and accurately communicate with the physician/provider any pertinent change in condition of a resident. Notification of Changes in Resident's Status Policy has been reviewed and revised to include that the phone should be utilized or in person for all communication regarding significant change in status with physician/provider. Documentation to include physician/provider response. Education has been provided to all RNs and LPNs regarding the revised facility policy of Notifying Changes in Resident's Status. This education included assessing residents after change in condition, appropriate and complete notification of the physician/provider and method of notification. 85% of all RNs and LPNs have completed education by the end of the day 12/4/24. 100% of RNs and LPNs completed education by the end of the day 12/6/24.	Completion Date: **12/06/2024** Status: **APPROVED** Date: **12/23/2024**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940**

(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 0684 SS=J	Continued from page 2	F 0684	Every fall incident will be audited by interdisciplinary team to assure that appropriate and complete physician/provider notification has occurred. The audit will be reported on at Quality Assurance and Performance Improvement (QAPI) meeting by DON/Designee for a minimum of four quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940**

(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 0684 SS=J	Continued from page 3 Based on review of clinical records, hospital records, facility documentation, facility policies, FDA (Food and Drug Administration) guidelines, and interviews with staff, it was determined the facility failed to provide care and services that meet the professional standards of quality and as outlined in resident's plan of care for one of 13 residents reviewed (Resident R17). The facility failed to accurately and timely notify the physician after Resident R17 who was on blood thinner medication, sustained a fall in the bathroom. The facility failed to conduct comprehensive assesment of Resident R17 in a timely manner after the resident showed abnormal blood pressure levels following the fall and after the administration of a routine anti-coagulant medication. The facility's failure resulted in Resident R17 not receiving emergency medical care for approximately 10 hours after the fall, sustaining a subdural hemorrhage which required transfer to the hospital and expiring in the hospital. This failure placed Resident R17 in an Immediate Jeopardy situation. (Resident R17)	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940**

(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 0684 SS=J	Continued from page 4 Findings Include: Review of facility policy "Notification of Changes in Resident's Status" dated March 2020, revealed "Purpose: To assure that each resident and/or resident representative is notified timely of accidents that result in injury and have the potential for physician intervention; significant changes in status; significant changes in treatment; abnormal lab, radiology or other diagnostic test results; transfer or discharge associated with the health or safety of the resident; change in roommate status or change in resident rights under Federal or State law or regulations. Further review of facility policy revealed "Pennswood Village shall provide timely notification to each resident and/or resident representative of accidents that result in injury and have the potential for physician intervention, significant changes in condition, significant change in treatment, transfer/discharge status related to health or safety	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940**

(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 0684 SS=J	Continued from page 5 of the resident or other individuals in the facility, roommate status or change in resident rights under Federal or State law or regulations. The Community will notify the physician in person, by telephone or in writing of the following changes or events: a. An accident which results in injury and has the potential for requiring physician intervention. b. A significant change in physical, mental, or psychosocial status. Significant change is a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications. c. Abnormal lab, radiology or other diagnostic test results may be communicated to the ordering clinician. d. A need to alter treatment significantly. Significant alteration is the need to discontinue or change an existing form of treatment due to adverse consequences, or to commence new form of treatment. e. A decision to transfer or discharge a resident	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940**

(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 0684 SS=J	Continued from page 6 related to health or safety of the resident or other individuals in the facility." Review of FDA guidelines for the medication Xarelto revealed that "XARELTO increases the risk of bleeding and can cause serious or fatal bleeding. In deciding whether to prescribe XARELTO to patients at increased risk of bleeding, the risk of thrombotic events should be weighed against the risk of bleeding. Promptly evaluate any signs or symptoms of blood loss and consider the need for blood replacement. Bleeding Risks -advise patients to report any unusual bleeding or bruising to their physician. Inform patients that it might take them longer than usual to stop bleeding, and that they may bruise and/or bleed more easily when they are treated with XARELTO [see Warnings and Precautions (5.2)]. If patients have had neuraxial anesthesia or spinal puncture, and particularly, if they are taking concomitant NSAIDs (non-steroidal anti-inflammatory) or platelet inhibitors, advise patients to watch for signs and symptoms of spinal or epidural hematoma, such as back pain, tingling,	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: 164002	1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940

(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 0684 SS=J	Continued from page 7 numbness (especially in the lower limbs), muscle weakness, and stool or urine incontinence. If any of these symptoms occur, advise the patient to contact his or her physician immediately." "Increased risk of bleeding: XARELTO can cause bleeding which can be serious and may lead to death. This is because XARELTO is a blood thinner medicine (anticoagulant) that lowers blood clotting. During treatment with XARELTO you are likely to bruise more easily, and it may take longer for bleeding to stop. You may have a higher risk of bleeding if you take XARELTO and have certain other medical problems." Review of facility reported incident dated November 25, 2024, revealed Resident R17 was noted on November 25, 2024, at approximately 3:00 a.m. observed sitting on the floor in the bathroom with the resident's back against the wall. The resident's pants were down, and the floor was wet with urine. Resident R17 stated, "I hit my head." The resident was awake and alert, speech was clear	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940**

(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 0684 SS=J	Continued from page 8 and answered appropriately. Neuro checks initiated and was within normal limits. "Resident was able to move all extremities and denied pain. [Resident R17] was noted with increased blood pressure post fall, which was discussed with [Nurse Practitioner, Employee E4], as well as current clinical presentation offering no other complaints at this time and no visible signs of injury, recommended to continue current plan of care and give morning medications." Morning medications given including Furosemide and Cardizem. In the early afternoon around 12:30 p.m. the resident was noted with complaint of head pain, left eye pain, nausea, as well as vomiting. The physician was called, and ordered to send the resident to the hospital for evaluation. Resident was transferred to the hospital. Upon arriving to the emergency room, a CT (computed tomography) scan was completed and Resident R17 was noted with a 16 millimeter (mm) subdural hematoma (pool of blood between the brain and its outermost covering) with a 6 mm midline shift (displacement of brain tissue that occurs when the brain is pushed to one side of its natural centerline. It	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940**

(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 0684 SS=J	Continued from page 9 can be caused by a number of things, including traumatic brain injury). "Family wished for conservative management per trauma team and no surgical intervention, goal was comfort." Resident R17 passed away at the hospital. Review of facility incident report dated November 25, 2024, revealed that Resident R17 was found sitting on the floor. Resident stated, "I hit my head", The time of the incident was documented as 2:05 a.m. Further review of the incident report revealed that the physician notification time was 3:40 a.m. There was no documentation of mode of communication and physician response. There was no documented evidence that physician responded to the notification. Review of medication administration record for Resident R17 for November 2024 revealed that the resident received Xarelto 15 milligrams (mg) every evening at 6 p.m. and the resident received a dose on November 24, 2024.	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940**

(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 0684 SS=J	Continued from page 10 Review of care plan for Resident R17 dated November 8, 2024 revealed that resident was on anticoagulant therapy Xarelto related to Atrial fibrillation (irregular and rapid heartbeat) with care plan intervention including monitor/document/report as needed adverse reactions of anticoagulant therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising , blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs. Review of neurological assessment dated November 25, 2024, at 2:15 a.m. revealed that resident's blood pressure (BP) after the fall was 190/80 (normal blood pressure is 120/80). It was also documented that the resident complained of pain of on a scale, 3 out of 10. There was no documentation of the pain location or type of pain. Review of neurological assessment dated November	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940**

(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 0684 SS=J	Continued from page 11 25, 2024, at 2:30 a.m. revealed that the blood pressure (BP) was 178/78. Review of neurological assessment dated November 25, 2024, at 2:45 a.m. revealed that the blood pressure (BP) was 170/78. Review of neurological assessment dated November 25, 2024, at 3:00 a.m. revealed that the blood pressure (BP) was 178/72. Review of neurological assessment dated November 25, 2024, at 3:30 a.m. revealed that the blood pressure (BP) was 180 /78. Review of neurological assessment dated November 25, 2024, at 4:00 a.m. revealed that the blood pressure (BP) was 177/78. Review of neurological assessment dated November 25, 2024, at 5:00 a.m. revealed that the blood pressure (BP) was 180/80. Review of neurological assessment dated November 25, 2024, at 6:00 a.m. revealed that the blood pressure (BP) was 170/80. Review of neurological assessment dated November 25, 2024, at 6:55 a.m. revealed that the blood pressure (BP) was 181/83.	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940**

(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 0684 SS=J	Continued from page 12 Review of neurological assessment dated November 25, 2024, at 7:55 a.m. revealed that the blood pressure (BP) was 185/80. Review of neurological assessment dated November 25, 2024, at 11:55 a.m. revealed that the blood pressure (BP) was 186/80. Review of neurological assessment dated November 25, 2024, at 12:15 p.m. revealed that the blood pressure (BP) was 192/80. Review of Resident R17's clinical record failed to reveal documented evidence the physician was notified of Resident R17's high blood pressure levels and the use of anticoagulant medication until November 25, 2024 approximately 7:30 a.m. Review of hospital record dated November 25, 2024, revealed Resident R17 presented for evaluation of the ground-level fall sustained at 2:00 a.m. 10 hours later resident developed headache, nausea, vomiting. In emergency room resident received Kcentra for reversal of Xarelto coagulopathy and seizure prophylaxis. CT scan	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940**

(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 0684 SS=J	Continued from page 13 revealed cerebral hemorrhage (16 mm subdural hematoma and 6 mm midline shift). Family chosen conservative management and comfort measures were initiated. Resident died on November 26, 2024, and the reason was documented as subdural hematoma. Interview with Nurse Practitioner, Employee E4 on December 2, 2024, at 12:07 p.m. stated she was not on call on November 25, 2024. She came to the facility around 7:00 a.m. and heard that the resident had a fall, later around 7:30 a.m. she became aware the resident was having high blood pressure. Employee E4 stated resident was due for (his/her) morning medication and she asked staff to give the medication. She did not order any other medication. She was not aware of resident's status until around 12 noon on November 25, 2024. Employee E4 stated staff were expected to recheck the blood pressure an hour or two after the medications were given and notify the provider to see response of the blood pressure or to initiate additional interventions.	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: 164002	1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940

(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 0684 SS=J	Continued from page 14 Interview with Registered Nurse, Employee E5 on December 2, 2024, at 12:28 p.m. stated she was the supervisor on duty for November 25, 2024. She asked the nurse to give the morning medication after the resident was noted with high blood pressure. She was not sure if the charge nurse rechecked Resident R17's blood pressure or if the blood pressure came down in response to the medication. Employee E5 stated later when she assessed the resident around 12 or 1 p.m. resident was vomiting and had nausea. Interview with Registered Nurse, Employee E6 on December 3, 2024, at 9:33 a.m. stated she was the night shift supervisor when the resident fell at 2:05 a.m. She created the incident report. She sent an e-mail (electronic communication) to physician around 3:40 a.m. to notify of the fall. Employee E6 stated she was not sure if any physician saw the e-mail or responded to the e-mail. Employee E6 stated she was aware that the resident hit her head during the fall. Employee E6 stated she was aware of the high blood pressure and confirmed the	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940**

(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 0684 SS=J	Continued from page 15 physician was not notified in a timely manner. Review of an e-mail message sent to the providers on November 25, 2024, at 3:45 a.m. revealed that "Hello, (Resident R17) fell last night in (Resident R17)'s bathroom, no apparent injuries at this time." Further review of the email notification failed to reveal evidence the staff notified the provider of resident hitting head, being on anticoagulant medication, pain level of 3, or high blood pressure after the fall. Interview with Nursing Home Administrator and Registered Nurse, Clinical Service Director, Employee E3 on December 3, 2024, at 9:33 a.m.. stated staff should call physician if there is a change in condition. Employee E7, Licensed Nurse, who provided care to the resident on November 25, 2024 when resident fell was not available for an interview. Interview with Physician, Employee E8 on	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940**

(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 0684 SS=J	Continued from page 16 December 3, 2024, at 2:00 p.m. stated staff should call the physician via phone if there an emergency or urgent care need that necessitates a physician response regardless of the time. Staff could e-mail for non-emergency notifications that require physician response but should complete a follow up call if no response received in an hour. Physician stated he was the physician for Resident R17. He stated that staff should notify the physician immediately after the fall via phone of a resident who sustain a fall with suspected head injury such as hitting head during fall. Staff should also make the physician aware if the resident is taking anticoagulant medication which increases risk for brain injury. The physician should also made aware of the high blood pressure or vital signs changes after a fall when resident hit their head. Physician, Employee E8 also stated that staff should re-check the blood pressure at least in two hours after a medication was given for high blood pressure. A follow up interview with Nurse Practitioner, Employee E4 on December 3, 2024, at 2:30 p.m.	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940**

(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 0684 SS=J	Continued from page 17 stated she was not aware the resident was on blood thinner medication when the staff notified them about Resident R17's high blood pressure after the fall. Employee E4 stated she would have looked at the resident's condition in a different way and would have changed her decision if she was aware of Resident R17 being on Xarelto. Employee E4 stated Xarelto increased the risk of head injury and bleeding after falls involving hitting the head. Interview with Nursing Home Administrator and Registered Nurse, Clinical Service Director, Employee E3 on December 3, 2024, at 2:40 p.m. confirmed the staff did not notify the physician in a timely and appropriate manner after Resident R17 sustained a fall in which the resident hit his/her head and observed with pain, high blood pressure. Nursing Home Administrator and Employee E3 confirmed there was no documented evidence that the staff notified the resident's physician of high-risk anticoagulant medication which the resident was taking. Nursing Home Administrator and Employee E3 also confirmed there was no documented	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: 164002	1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940

(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 0684 SS=J	Continued from page 18 evidence the staff re-checked Resident R17's blood pressure in timely manner after medication was administered for high blood pressure. An Immediate Jeopardy situation was identified to the Nursing Home Administrator on December 4, 2024, at 1:16 p.m. for the facility's failure to provide care and services that meets the professional standards of quality and as outlined in resident's plan of care. Failure to accurately and timely notify the physician after Resident R17 who was on a blood thinner medication, fell in the bathroom and hit he/her head. Failure to re-assess Resident R17 in a timely manner after the resident experience in abnormal high blood pressure levels following the fall and after routine medication was administered. These failure placed Resident R17 at risk for serious harm including death. The facility submitted a written plan of action on December 4, 2024, and implemented a plan of action which included the following:	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940**

(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 0684 SS=J	Continued from page 19 - Facility will immediately and accurately communicate with the physician/provider any pertinent change in condition of a resident. - Notification of Changes in Resident's Status Policy has been reviewed and revised to include that the phone should be utilized or in person for all communication regarding significant change in status with physician/provider. Documentation to include physician/provider response. - Education has been implemented of all RNs (Register Nurse) and LPNs (Licensed Practical Nurse) regarding the revised facility policy of Notifying Changes in Resident's Status. This education includes assessing residents after change in condition, appropriate and complete notification of the physician/provider and method of notification. 85% of all RNs and LPNs will have completed education by the end of the day 12/4/24. 100% of RNs and LPNs will have completed education by the end of the day 12/5/24. If staff are not available, they will be educated prior to the start of their next shift in facility. - Every fall incident will be audited by	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: 164002	1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940

(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 0684 SS=J	Continued from page 20 interdisciplinary team to assure that appropriate and complete physician/provider notification has occurred. The audit will be reported on at Quality Assurance and Performance Improvement (QAPI) for four quarters. On December 4, 2024, at 3:47 p.m. the action plan was reviewed, additional clinical records were reviewed, policy verified, interviews were conducted with staff to confirm that the in-service education was completed. The Immediate Jeopardy was lifted on December 4, 2024, at 4:02 p.m. 201.14(a) Responsibility of licensee 201.18(b)(1) Management 211.12(d)(1)(2)(3)(5) Nursing services	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940**

(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 0835 SS=D		F 0835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940**

(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 0835 SS=D	Continued from page 22 483.70 Administration §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 0835	The Nursing Home Administrator and Director of Nursing will fulfill essential duties and responsibilities of their position to ensure that the Federal and State guidelines and regulation are followed. Nursing Home Administrator and Director of Nursing reviewed and revised the Notification of Changes in Resident's Status Policy. The revision includes that the phone should be utilized or in person for all communication regarding significant change in status with physician/provider. Documentation to include physician/provider response. Education has been provided to all RNs and LPNs regarding the revised facility policy of Notifying Changes in Resident's Status. Nursing Home Administrator and Director of Nursing will continue to attend continuing education (CEU) approved by their state boards on a biennial basis. NHA will continue to	Completion Date: **12/06/2024** Status: **APPROVED** Date: **12/23/2024**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940**

(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 0835 SS=D	Continued from page 23	F 0835	complete 48 hours of continuing education every two years that are approved by the Board of Examiners of Nursing Home Administrators or National Association of Long-Term Care Administrator Boards (NAB). DON will continue to complete 30 hours of continuing education every two years that are approved by the State Board of Nursing. NHA/Designee and DON/Designee will conduct a root cause analysis on all reportable incidents submitted to Department of Health. Reportable incidents and their root cause analysis will be reported on at Quality Assurance and Performance Improvement (QAPI) meeting for a minimum of four quarters by NHA/Designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940**

(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 0835 SS=D	Continued from page 24 Based on review of facility records, job descriptions, and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) did not effectively manage the facility related to ensuring that the facility provided care and services that met the professional standards of quality and as outlined in resident's plan of care. Nursing Home Administrator and Director of Nursing failed to ensure that accurately and timely notification of the physician after Resident R17 who was on a blood thinner medication, fell in the bathroom. Nursing Home Administrator and Director of Nursing failed to ensure proper procedures were followed related to re-assessing Resident R17 in a timely manner after the resident was assessed with elevated blood pressure levels following a fall and after routine medication was administered. This placed Resident R17 at risk for serious harm or impairment and resulted in an immediate jeopardy situation for one of 13 residents reviewed. (Resident R17) Findings include:	F 0835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940**

(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 0835 SS=D	Continued from page 25 Review of the job description for the Nursing Home Administrator (NHA) revealed that "The Nursing Home Administrator assures regulatory operations of (facility name) in accordance with current federal, state, county, local... standards. The Nursing Home Administrator oversees Quality Assurance and Performance Improvement and HIPAA programs. The Nursing Home Administrator is a member of the Senior Management Team, sharing the overall responsibility for the operations of the Community. Develop, maintain, and assure compliance with written policies and procedures... Interpret policies to staff, residents, families, visitors and government agencies. Review accidents and incidents and make recommendations for an effective safety program for residents. Perform the duties of abuse investigator. This includes, but is not limited to, carrying out abuse investigation and prevention protocol. Initiate and coordinate abuse investigations." Review of the job description for the Director of Nursing (DON) revealed that "The Director of	F 0835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940**

(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 0835 SS=D	Continued from page 26 Nursing is authorized to take any reasonable action necessary to carry out the responsibility delegated to her/him so long as such action does not deviate from established policy and practice as defined by Pennswood Village and the current Pennsylvania Professional Nursing Practice Act in the management of all resident services in the Skilled Nursing Facility. Directs, coordinates, and supervises the nursing activities of (facility name). Complies with federal, state, and local regulations and standards for operating a long-term care facility. Coordinates housekeeping, food, transportation, and maintenance personnel as they relate to the (facility name) with the assistance of the department heads involved. Assist in establishing and maintaining policies pertaining to all aspects of total resident care in (facility name). Review and ensure compliance of (facility name) with federal, state, and local standards and implement these standards. Review and ensure compliance with established personnel policies... Consult with Medical Director to ensure implementation of medical policy and the individual resident's plan of care.	F 0835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940**

(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 0835 SS=D	Continued from page 27 Review of facility policy "Notification of Changes in Resident's Status" dated March 2020, revealed "Purpose: To assure that each resident and/or resident representative is notified timely of accidents that result in injury and have the potential for physician intervention; significant changes in status; significant changes in treatment; abnormal lab, radiology or other diagnostic test results; transfer or discharge associated with the health or safety of the resident; change in roommate status or change in resident rights under Federal or State law or regulations. Review of Federal Drug Administration guidelines for Xarelto revealed that "XARELTO increases the risk of bleeding and can cause serious or fatal bleeding. Increased risk of bleeding: XARELTO can cause bleeding which can be serious and may lead to death. This is because XARELTO is a blood thinner medicine (anticoagulant) that lowers blood clotting. During treatment with XARELTO you are likely to bruise more easily, and it may take longer	F 0835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: 164002	1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940

(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 0835 SS=D	Continued from page 28 for bleeding to stop. You may have a higher risk of bleeding if you take XARELTO and have certain other medical problems." Review of facility reported incident dated November 25, 2024, revealed that Resident R17 was noted on November 25, 2024, at approximately 3:00 a.m. sitting on the floor in her/his bathroom with her back against the wall. The resident's pants were down, and the floor was wet with urine. Resident R17 stated, "I hit my head". The resident was awake and alert, speech was clear and was able to answer appropriately. Neuro checks initiated and was within normal limits. Resident was able to move all extremities and she denied pain. Resident R17 was noted with increased blood pressure post fall, which was discussed with Employee E4, Nurse Practitioner as well as current clinical presentation offering no other complaints at this time and no visible signs of injury, recommended to continue current plan of care and give morning medications. Morning medications given including Furosemide and Cardizem. In the early afternoon	F 0835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: 164002	1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940

(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 0835 SS=D	Continued from page 29 around 12:30 p.m. Resident R17 was noted with complaint of head pain, left eye pain, nausea, as well as vomiting, provider called, and order obtained to send resident to the hospital for evaluation. Resident was transferred to the hospital. Upon arriving to the emergency room, a CT (computed tomography) scan was completed and Resident R17 was noted with a 16 millimeter (mm) Subdural hematoma (a pool of blood between the brain and its outermost covering) with a 6 mm midline shift (a displacement of brain tissue that occurs when the brain is pushed to one side of its natural centerline. It can be caused by a number of things, including traumatic brain injury). Family wished for conservative management per trauma team and no surgical intervention, goal was comfort. Resident R17 passed away at the hospital. Review of facility incident report dated November 25, 2024, revealed that Resident R17 was found sitting on the floor. Resident stated, "I hit my head." The time of the incident was documented as 2:05 a.m. Further review of the incident report revealed	F 0835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940**

(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 0835 SS=D	Continued from page 30 that the physician notification time was 3:40 p.m. There was no documentation of mode of communication and physician response. There was no documented evidence that physician responded to the notification. Review of medication administration record for Resident R17 for November 2024, revealed that the resident received the anti-coagulant medication Xarelto 15 milligrams (mg) every evening at 6 p.m. and the resident received the last dose on November 24, 2024. Review of neurological assessment from November 25, 2024, at 2:30 a.m. through November 25, 2024 at 12:15 p.m. revealed that resident's blood pressure (BP) was elevated. It was also documented that the resident complained of pain of on a scale, 3 out of 10. There was no documentation of the pain location or type of pain. There was no documented evidence in the clinical record that the physician was notified of Resident	F 0835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: 164002	1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940

(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 0835 SS=D	Continued from page 31 R17's high blood pressure levels and her use of anticoagulant medication after the fall until approximately November 25, 2024 at 7:30 a.m.. Resident R17's neuro check showed abnormal/elevated blood pressure throughout all the assessment. Review of hospital record date November 25, 2024, revealed that Resident R17 presented for evaluation of the ground-level fall sustained at 2:00 a.m. 10 hours later resident developed headache, nausea, vomiting. In emergency room resident received Kcentra for reversal of Xarelto coagulopathy and seizure prophylaxis. CT scan revealed cerebral hemorrhage 16 mm subdural hematoma and 6 mm midline shift. Family chosen conservative management and comfort measures were initiated. Resident died on November 26, 2024 and the reason was documented as subdural hematoma. Interview with Registered Nurse, Employee E6 on December 3, 2024, at 9:33 a.m. stated she was the	F 0835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940**

(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 0835 SS=D	Continued from page 32 night shift supervisor when the resident fell at 2:05 a.m. She created the incident report. She sent an e-mail (electronic correspondence) to physician around 3:40 a.m. to notify of the fall. Employee E6 stated she was not sure if any physician saw the e-mail or responded to the e-mail. Employee E6 stated she was aware that the resident hit her/his head during the fall. Employee E6 stated she was aware of the high blood pressure and confirmed that the physician was not notified in a timely manner. Review of an e-mail message sent to the providers on November 25, 2024, at 3:45 a.m. revealed that "Hello, (Resident R17) fell last night in her bathroom, no apparent injuries at this time". Further review of the e-mail notification revealed no evidence that the staff notified the provider of resident hitting head, being on anticoagulant medication, pain level of 3 or high blood pressure after the fall. Interview with Administrator and Registered Nurse, Clinical Service Director, Employee E3 on	F 0835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD** **NEWTOWN, PA 18940**

(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 0835 SS=D	Continued from page 33 December 3, 2024, at 9:33 a.m... stated staff should call physician if there is a change in condition. Interview with Physician on December 3, 2024, at 2:00 p.m. stated staff should call the physician via phone if there an emergency or urgent need that need a physician response regardless of the time. Staff could email for non-emergency notifications that require physician response but should complete a follow up call if no response received in an hour. Physician stated she was the physician for Resident R17. He stated staff should notify the physician immediately after the fall via phone of residents sustain fall with suspected head injury such as hitting head during fall. Staff should also make the physician aware if the resident is taking anticoagulant which increases risk for brain injury. Physicians should also made aware of the high blood pressure or vital signs changes after a fall when resident hit their head. Physician also stated staff should recheck the blood pressure at least in two hours after a medication was given for high blood pressure.	F 0835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940**

(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 0835 SS=D	Continued from page 34 A follow up interview with Nurse Practitioner, Employee E4 on December 3, 2024, at 2:30 p.m. stated she was not aware that the resident was on blood thinner when the staff notified them about Resident R17's high blood pressure after the fall. Employee E4 stated she would have looked the resident's condition in a different way and would have changed her decision if she was aware of Resident R17 being on Xarelto. Employee E4 stated Xarelto increased the change of head injury and bleeding after fall involving hitting the head. Interview with Nursing Home Administrator and Registered Nurse, Clinical Service Director, on December 3, 2024, at 2:40 p.m. confirmed that the staff did not notify the physician in a timely and appropriate manner after Resident R17 sustained a fall, observed with pain, and assessed with high blood pressure. Nursing Home Administrator and Employee E3 confirmed that there was no documented evidence that the staff notified the physician of high-risk anti-coagulant medication which the resident was taking. Nursing Home	F 0835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD** **NEWTOWN, PA 18940**

(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 0835 SS=D	Continued from page 35 Administrator and Employee E3 also confirmed that there was no documented evidence that the staff re-checked Resident R17's blood pressure in timely manner after medication was administered for high blood pressure. Based on the deficiencies identified in this report, the Nursing Home Administrator and Director of Nursing failed to fulfill essential duties and responsibilities of their position to ensure that the Federal and State guidelines and regulations were followed, contributing to the Immediate Jeopardy situation. Refer to F684 28 Pa. Code: 201.18(b)(1) Management 28 Pa. Code: 201.18(b)(3) Management	F 0835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395473	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNSWOOD VILLAGE STATE LICENSE NUMBER: **164002**	**1382 NEWTOWN LANGHORNE RD NEWTOWN, PA 18940**

(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 0835 SS=D	Continued from page 36	F 0835		

Certified End Page

PENNSWOOD VILLAGE

STATE LICENSE NUMBER: 164002

SURVEY EXIT DATE: 12/05/2024

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

Jeanne Parisi
Deputy Secretary for Quality Assurance

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

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY