STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395533	A. BLDG: 00 B. WING:	07/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HERITAGE RIDGE SENIOR LIVING AT WINDY HILL STATE LICENSE NUMBER: **164302**	**100 DOGWOOD DRIVE** **PHILIPSBURG, PA 16866**

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F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification Survey, State Licensure Survey, Civil Rights Compliance Survey, and an Abbreviated Survey to investigate a Complaint, completed on July 10, 2025, it was determined that Heritage Ridge Senior Living at Windy Hill was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0607 SS=D		F 0607		

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 0607 SS=D	Continued from page 1 483.12(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	Attempts were made to collect additional investigative statements on resident #12's without success and education was provided to the nursing staff on this situation. A review of incident reports since the transition to our current company was completed for accuracy and investigation completion for educational purposes to the staff. Education based on the incidents review was conducted as well as the facility policies content was explained to ensure clinical, and non-clinical staff are aware as well as staff in general of the need and necessity to report these matters immediately and the need for thorough statements from anyone with knowledge of such situations and incidents. Audits will be performed on incident reports requiring follow-up and investigation on a weekly basis for 1 month and bi-weekly for 3 months	Completion Date: **08/19/2025** Status: **APPROVED** Date: **08/01/2025**

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F 0607 SS=D	Continued from page 2 This REQUIREMENT is not met as evidenced by:	F 0607	thereafter. Findings will be presented to the Quality Assurance Performance Improvement committee for recommendations, an explanation of any identified variance infractions.	

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F 0607 SS=D	Continued from page 3 Based on clinical record review, review of select facility policies and procedures, and staff interview, it was determined that the facility failed to thoroughly investigate a resident's injury of unknown origin for one of 18 sampled residents (Resident 12). Findings include: The policy entitled Abuse, Neglect, Exploitation, or Misappropriation Reporting and Investigating, last reviewed without changes on February 26, 2025, revealed if resident abuse, neglect, exploitation, misappropriation of resident property, or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator, and other officials according to state law. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of the residents. All allegations are thoroughly investigated.	F 0607		

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F 0607 SS=D	Continued from page 4 Clinical record review revealed the facility admitted Resident 12 on May 19, 2024. Nursing documentation dated April 15, 2025, at 1:38 PM indicated nursing staff noted a bruise to Resident 12s inner thigh. Review of the facility investigation revealed the facility only obtained one witness statement from the nurse aide discovering the bruise and the statement indicated Resident 12s bruise was found during morning care and the Resident 12 stated he did not know how he obtained the bruise. Nursing documentation dated June 17, 2025, at 7:00 PM noted nurse aides indicated when providing evening care and assisting Resident 12 into bed, the nurse aides noticed a large bruise to his left shoulder/back. Documentation noted the nurse assessed the area and the bruise measured 12 by 20 centimeters. Documentation noted Resident 12 does not know what happened. Documentation noted staff were educated on proper use of the sit to stand lift, as well as following therapy orders for transfers. Review of the facility investigation into Resident 12s	F 0607		

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F 0607 SS=D	Continued from page 5 bruise revealed the facility only obtained two witness statements from the nurse aides discovering the bruise. Further review revealed no evidence of staff education, or any statements other than from the staff discovering Resident 12s bruise. Interview with the Nursing Home Administrator on July 10, 2025, at 10:49 AM confirmed these findings. The facility failed to thoroughly investigate Resident 12s bruises to rule out abuse or prevent further injuries. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a)(c) Resident rights	F 0607		
F 0628 SS=E		F 0628		

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F 0628 SS=E	Continued from page 6 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) Discharge Process §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i) (A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-	F 0628	The facility provides a written Bed Hold Acknowledgment and Notice of Transfer document containing all the required elements to include date of transfer, specific reason of discharge/transfer, location to be transferred, right to appeal process information and the information pertaining to the Office of the Long-Term Care Ombudsmen to the responsible party to those residents identified (#28, 59, and 65). A copy of the Bed Hold Acknowledgment and the Notice of Transfer Document was sent to residents #28, #59, and #65. Once a copy of the signed documents is returned, they will be filed in the resident's medical chart. A review of the facility's resident records, who were transferred over the past 6 (six) months, will be completed, and corrective actions will be taken if necessary. Education was provided by Social Services and the Admissions Director on the Notice Requirements	Completion Date: **08/19/2025** Status: **APPROVED** Date: **07/31/2025**

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F 0628 SS=E	Continued from page 7 (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)(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.	F 0628	before Transfer/Discharge Notification Program and the process to be completed upon each transfer. Education was provided to all Nursing Staff. Any future transfers will be reviewed by the Admission Director at the morning meeting (5 days per week) to ensure proper procedures were followed for the Notice Requirements before Transfer/Discharge process to include the initial notification verification, and the written notification of the transfer/discharge and the reasons for the move. Audits will be completed on all transfers weekly for two months and bi-weekly for 3 months. Findings will be presented to the Quality Assurance Performance Improvement committee for recommendations, an explanation of any identified variance infractions.	

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F 0628 SS=E	Continued from page 8 §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 (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	F 0628		

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F 0628 SS=E	Continued from page 9 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(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;	F 0628		

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F 0628 SS=E	Continued from page 10 (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).	F 0628		

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F 0628 SS=E	Continued from page 11 This REQUIREMENT is not met as evidenced by:	F 0628		

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F 0628 SS=E	Continued from page 12 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident and/or their representative received written notice of transfer and written notice of the facility bed-hold policy at the time of transfer for three of five residents reviewed for hospitalization (Residents 28, 59, and 65). Findings Include: Nursing documentation for Resident 65 dated May 15, 2025, at 11:58 PM revealed that the resident had a change in condition and 911 was called. A Medication Administration Note dated May 16, 2025, at 5:36 AM revealed that Resident 65 was admitted to the hospital for a urinary tract infection. A review of the census for Resident 65 revealed that the resident returned to the facility on May 21, 2025. Clinical record review revealed no documentation to	F 0628		

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F 0628 SS=E	Continued from page 13 indicate that Resident 65 and/or their representative received a written notice of transfer and a written notice of the facility bed-hold policy at the time of transfer. Documentation was also requested by the surveyor during meetings with the Nursing Home Administrator and Director of Nursing on July 8, 2025, at 2:10 PM and July 9, 2025, at 2:00 PM. An interview with the Director of Nursing on July 10, 2025, at 12:59 PM confirmed there was no documentation to indicate that Resident 65 and/or their representative received written notice of transfer and written notice of the facility bed-hold policy at the time of transfer. Clinical record review for Resident 59 revealed that he was transferred to the emergency room to be evaluated for mental status changes, weakness, and frequent falls on March 12, 2025. He was admitted to the hospital from the emergency room for weakness and pneumonia. Clinical record review revealed no documentation to	F 0628		

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F 0628 SS=E	Continued from page 14 indicate that Resident 59 and/or their representative received a written notice of transfer and a written notice of the facility bed-hold policy at the time of transfer. Documentation was also requested by the surveyor during meetings with the Nursing Home Administrator and Director of Nursing on July 9, 2025, at 2:17 PM. The facility failed to provide a written notice of transfer and a written notice of bed-hold that included all the written components to the resident and/or the resident's responsible party at the time of transfer for Resident 59. Clinical record review revealed Resident 28 was transferred to the hospital from April 30 to May 2, 2025, for a change in his condition. Further review revealed no documentation to indicate that Resident 28s representative received a written notice of transfer and a written notice of the facility bed-hold policy at the time of transfer. Interview with Employee 4 (social worker) and	F 0628		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HERITAGE RIDGE SENIOR LIVING AT WINDY HILL STATE LICENSE NUMBER: **164302**	**100 DOGWOOD DRIVE PHILIPSBURG, PA 16866**

(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 0628 SS=E	Continued from page 15 Employee 5 (admissions) on July 10, 2025, at 9:57 AM confirmed these findings for Resident 28. 28 Pa. Code 201.14(a) Responsibility of license 28 Pa. Code 201.29(a) Resident rights	F 0628		
F 0676 SS=D		F 0676		

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 0676 SS=D	Continued from page 16 483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting,	F 0676	The facility identified the item noted, and Resident #12 has had a new screening for speech therapy completed and changes were implemented. No evidence or actual ill effects exist on any resident in our community due to lack of adherence to the requirements of activities of daily living. Education was conducted by the director of nursing or designee on MDS assessments and the process on how changes in condition should be documented, and interventions should be implemented to mitigate declines. Audits on five medical charts will be conducted to ensure compliance with appropriate assessments from identified findings weekly for one month and bi-weekly for three months. Findings will be presented to the Quality Assurance Performance Improvement committee for recommendations, an explanation	Completion Date: **08/19/2025** Status: **APPROVED** Date: **07/31/2025**

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 0676 SS=D	Continued from page 17 §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by:	F 0676	of any identified variance infractions.	

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F 0676 SS=D	Continued from page 18 Based on clinical record review and staff interview, it was determined that the facility failed to provide care and services to maintain or improve the ability to perform activities of daily living for one of two residents reviewed for eating concerns (Resident 12). Findings include: Clinical record review for Resident 12 revealed an MDS (Minimum Data Set, assessment completed at specific intervals to determine care needs) assessment dated April 17, 2025, that staff assessed Resident 12 as requiring the supervision with set up help only for eating. Resident 12's next MDS assessment dated June 22, 2025, revealed staff assessed Resident 12 as now requiring extensive assistance of one staff for eating. There was no documented evidence in Resident 12's clinical record to indicate that the facility identified or assessed Resident 12s decline in her ability to perform this activity of daily living.	F 0676		

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F 0676 SS=D	Continued from page 19 Interview with Employee 2 (registered nurse assessment coordinator) on July 10, 2025, at 11:45 AM confirmed these findings and stated that she would submit a screen for speech therapy to assess Resident 12s decline in his ability to feed himself. The surveyor reviewed the above findings for Residents 12 with the Director of Nursing and the Nursing Home Administrator on July 9, 2025, at 12:05 PM. The facility was unable to provide any further documentation that the facility assessed Resident 12's decline in eating ability or implemented any measures to mitigate the decline. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0676		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 20 483.25 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	The facility verified the need for resident #384's order for pacemaker checks and obtained an order for such actions to be performed, and the care plan was updated. Resident #43's MAR was reviewed, and again no documented evidence as to why this was occurring could be found. It was reiterated to clinical staff that if no specific order exists, and the medication will be administered in accordance with the physician specified paraments. No ill effect is evident for either resident #43 or resident #384. A review of resident charts was conducted by nursing staff for any potential medication being given outside the parameters of order as given by the provider. Any noted infractions were discussed with the provider and corrected. Residents with pacemakers and pacemaker care plans were reviewed for appropriate provider orders to monitor pacemaker checks. Corrective actions were taken on any identified resident charts affected by this	Completion Date: **08/19/2025** Status: **APPROVED** Date: **08/01/2025**

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 21	F 0684	review. Education was provided to licensed staff on the facilities policy and procedures on the correct monitoring and adherence to residents with pacemakers and medication administration. Audits on five medical charts will be conducted to ensure compliance with appropriate assessments from identified findings weekly for one month and bi-weekly for three months. Findings will be presented to the Quality Assurance Performance Improvement committee for recommendations, an explanation of any identified variance infractions.	

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F 0684 SS=D	Continued from page 22 Based on clinical record review and staff interview, it was determined that the facility failed to provide the highest practicable care regarding physician ordered medication parameters for one of one resident reviewed for concerns (Resident 43) and failed to provide the highest practicable care regarding pacemaker care for one of one resident reviewed (Resident 384). Findings include: Clinical record review for Resident 43 revealed a diagnosis list that included hypertension (high blood pressure), essential hypertension, and paroxysmal atrial fibrillation (an irregular heartbeat that comes and goes). Review of Resident 43's current care plan revealed the resident has an altered cardiovascular status related to the medical history. An intervention included to administer medications as ordered. A review of the current physician orders for	F 0684		

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F 0684 SS=D	Continued from page 23 Resident 43 dated May 6, 2025, indicated for staff to administer Metoprolol Succinate ER Extended Release (a medication that is used to treat high blood pressure and/or heart rate) 25 milligrams (mg) give one tablet orally at bedtime related to essential hypertension. Hold if systolic blood pressure (SBP, the top number of a blood pressure reading where the heart contracts) less than or equal to 110 or a heartrate less than or equal to 70. A review of the Medication Administration Record (MAR) for Resident 43 revealed that the Metoprolol was marked as administered outside of the physician specified parameters for the following: May 9, 2025: the pulse was documented as 62. May 10, 2025: the pulse was documented as 65. May 11, 2025: the pulse was documented as 70. May 13, 2025: the pulse was documented as 62. June 9, 2025: the pulse was documented as 67. June 10, 2025: the pulse was documented as 69. June 11, 2025: the pulse was documented as 70. July 4, 2025: the pulse was documented as 68.	F 0684		

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F 0684 SS=D	Continued from page 24 July 8, 2025: the pulse was documented as 63. There was no documentation for Resident 43 as to why the medication was administered outside of the specific physician ordered parameters. The above information for Resident 43 was reviewed in a meeting with the Director of Nursing (DON) on July 10, 2025, at 12:24 PM. The DON confirmed on July 10, 2025, at 12:59 PM that there was no documented evidence as to why the medication was administered outside of the physician ordered parameters. Clinical record review for Resident 384 revealed an order dated July 3, 2025, for him to have a chest x-ray because he had tachycardia (fast heart rate) and a fever. The results of the chest x-ray indicated that Resident 384 had some infiltrates (areas that are whiter, such as fluid, inflammatory cells, or other material). The	F 0684		

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F 0684 SS=D	Continued from page 25 x-ray also noted that Resident 384 had a cardiac pacemaker (a device that is used to regulate the hearts rhythm. Review of Resident 384's pacemaker care plan initiated on June 9, 2025, revealed an intervention to monitor pacemaker checks. Review of Resident 384's current physician order revealed no evidence of orders for pacemaker checks. An interview with the DON on July 9, 2025, at 12:20 PM revealed that she was unaware and unsure if Resident 384 had a pacemaker but would investigate and get back to the surveyor. A follow-up interview with the DON on July 10, 2025, at 9:45 AM confirmed the above noted findings that there were no orders related to Resident 384's pacemaker or pacemaker checks. The facility failed to provide the highest practicable care regarding physician ordered medication	F 0684		

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F 0684 SS=D	Continued from page 26 parameters for Resident 43 and failed to provide the highest practicable care regarding pacemaker care for Resident 384. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0684		
F 0688 SS=E		F 0688		

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F 0688 SS=E	Continued from page 27 483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 0688	The facility completed a review of resident #19's ROM/Mobility tasks in point click care. Tasks were updated and staff implemented said tasks. No evidence or actual ill effects exist on any resident in our community due to lack of adherence to the requirements of increase/prevent decreases in ROM/mobility. A report was generated to indicate residents with range of motion or mobility issues, and those identified were reviewed individually, and any related issues were updated, and staff instructed to implement said tasks. An education session was completed by the director of nursing or designee with clinical and therapy staff to ensure proper communication between nursing and therapy disciplines, documentation on point of care and tasks being initiated on point click care. A review of 10 records will be	Completion Date: **08/19/2025** Status: **APPROVED** Date: **08/01/2025**

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F 0688 SS=E	Continued from page 28	F 0688	completed weekly for one month for any identified residents with ROM/Mobility tasks and bi-weekly for 3 months. Findings will be presented to the Quality Assurance Performance Improvement committee for recommendations, an explanation of any identified variance infractions.	

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F 0688 SS=E	Continued from page 29 Based on clinical record review and resident and staff interviews, it was determined that the facility failed to provide services to maintain a resident's range of motion (RON) for one of two residents reviewed for ROM concerns (Resident 19). Findings include: Interview with Resident 19 on July 9, 2025, at 10:30 AM revealed that he receives no follow through after therapy discharges him. He said the therapist will tell him that staff are going to do exercise to his legs, but it either does not happen or does not happen consistently. Clinical record review of a physical therapy discharge summary dated May 15, 2025, revealed that resident was to receive a restorative active range of motion program (resident can move extremity on his own) and passive range of motion (staff move the extremity through range of motion) program to his lower extremities.	F 0688		

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F 0688 SS=E	Continued from page 30 Review of the facilitys task documentation revealed that Resident 19 was receiving a restorative active assist range of motion program to his bilateral lower extremities that was documented as being done through May 15, 2025. May 16 to 31, 2025, there was no documentation to indicate Resident 19 received the therapy recommended range of motion programs to his bilateral lower extremities. Interview with the Director of Nursing on July 10, 2025, at 10:00 AM revealed that there was a communication issue between therapy and nursing so Resident 19s recommended range of motion program never got initiated until June1, 2025. Review of Resident 19s task documentation for June 2025, revealed that he was to receive active range of motion to his bilateral lower extremities on dayshift daily. Review of the documentation revealed that Resident 19 did not receive active range of motion to his bilateral lower extremities on the following days: June 2, 3, 4, 6, 9, 10, 14, 15, 16, 18, 19, 20, 22, 23, 25, 27, 28, 30, 2025.	F 0688		

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F 0688 SS=E	Continued from page 31 The Director of Nursing was made aware of the concerns related to Resident 19s range of motion program to his lower extremities on July 10, 2025, at 11:05 AM. 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0688		
F 0692 SS=E		F 0692		

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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 0692 SS=E	Continued from page 32 483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 0692	Upon identification of noted issue re: resident #28, IDT members, including the PA were notified of weight loss. Facility Physician Assistant assessed resident noting dx of Adult FTT and Severe Protein-Calorie Malnutrition. The provider discussed potential use of enteral/tube feedings to support resident nutrition status. Resident declined tube feeding/nutritional enteral support. Continue to assist resident #28 with feeding, continue to encourage meal, fluid, and supplement intake, and encourage oral fluids q 1hours. Comfort measures were orders by provider on July 17, 2025. Residents are weighed upon admission and at intervals determined by the IDT. Any weight change of 5# or more since the last assessed weight is retaken the next day for confirmation. The facility EMR notifies staff of significant changes in weight status as well. The weight alerts are reviewed and assessed by the facility Registered	Completion Date: **08/19/2025** Status: **APPROVED** Date: **08/01/2025**

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 0692 SS=E	Continued from page 33	F 0692	Dietitian along with other members of the IDT. If a significant change in weight is confirmed, the IDT including the resident physician and/or physician assistant will be notified. The current nutrition plan of care will be reviewed and adjusted as necessary. The facility Registered Nurse Assessment Coordinator will determine if resident qualifies for a significant change assessment and notify IDT members. Education and training was provided to clinical staff regarding the facility's weight program, and the need for timely resident reweighs was emphasized as part of this training. Weight reviews and trends will continue to be a part of the facility's Quality Assurance and Performance Improvement program. Audits will be completed on 5 charts weekly for one month and biweekly for 3 months in regard to the appropriate weights for monitoring and reporting purposes.	

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F 0692 SS=E	Continued from page 34	F 0692	Findings will be presented to the Quality Assurance Performance Improvement committee for recommendations, an explanation of any identified variance infractions.	

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F 0692 SS=E	Continued from page 35 Based on clinical record review, review of select facility policies and procedures, and staff interview, it was determined that the facility failed to implement interventions promote acceptable parameters of nutritional status for one of five residents reviewed for nutritional concerns (Residents 28). Findings include: The facility policy entitled Weight assessment and Intervention, last reviewed without changes February 26, 2025, revealed residents are weighed upon admission and at intervals established by the interdisciplinary team. Weights are recorded in each units weight record chart and in the individuals medical record. Any weight change of five pounds or more since the last weight assessment is retaken the next day for confirmation. Undesirable weight change is evaluated by the treatment team whether the criteria for significant weight change has been met. The physician and the multidisciplinary team identify conditions and medications that may be causing weight loss or increasing the risk of weight	F 0692		

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F 0692 SS=E	Continued from page 36 loss. Clinical record review revealed the facility admitted Resident 28 on February 20, 2025, with diagnoses including severe protein-calorie malnutrition. Review of Resident 28's documentation survey report for meal intakes revealed the following: June 2025, staff documented Resident 28 consumed zero to 25 percent on 52 of 90 meals. July 2025, staff documented Resident 28 consumed zero to 25 percent on 23 of 27 meals. Further review of Resident 28s clinical record revealed the following weight assessments: May 2, 2025, 119.0 pounds May 3, 2025, 119.0 pounds May 5, 2025, 114.5 pounds May 6, 2025, 115.0 pounds June 1, 2025, 95.0 pounds (a 20- pound, 17.39 percent severe weight loss, weight was crossed out by Employee 1, registered dietician, and she noted re-weighed)	F 0692		

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F 0692 SS=E	Continued from page 37 June 2, 2025, 103.0 pounds (weight crossed out by registered dietitian, noting re-weighed) July 2, 2025, 91.0 pounds (no evidence of a re-weight obtained the next day as per facility policy) July 7, 2025, 87.0 pounds (a 28- pound, 24.35 percent severe weight loss in two months) Review of Resident 28's clinical record revealed a Nutritional Risk Assessment dated May 6, 2025, noted Resident 28 is underweight with increased nutrient needs and impaired nutrient utilization related to low body weight, elevated nutrition requirements, and altered biochemical function. Employee 1 indicated they would monitor Resident 28's nutrition status and update his nutrition plan of care as needed. A Nutritional Risk Assessment date May 13, 2025, was completed with no changes. There was no further assessment of Resident 28's severe weight loss until July 7, 2025. Further review of Resident 28's clinical record revealed there were no weights obtained on	F 0692		

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F 0692 SS=E	Continued from page 38 Resident 28 from May 6, 2025, to July 2, 2025 (after Employee 1 crossed off other staff members weights assessments obtained on June 1 and June 2, 2025). There was no documentation of Resident 28 refused any weights during this time. Review of Resident 28's physician orders revealed that staff administered Resident 28 Med Pass (fortified nutritional shake) 2.0, 150 ML (milliliter), three times a day from February 21 to May 6, 2025, when Med Pass was discontinued and the facility ordered staff to administer Resident 28 Boost (nutritional supplement) twice a day. Review of Resident 28's Medication Administration Record (MAR, a form utilized to document the administration of medications and supplements) dated May 2025 revealed staff documented Resident 28 consumed less than 25 percent of Boost supplement on 32 of 51 administrations. Review of June 2025 MAR revealed that staff documented Resident 28 consumed less that 25	F 0692		

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F 0692 SS=E	Continued from page 39 percent of Boost supplement on 42 of 60 administrations. There was no documentation that Resident 28's physician assessed Resident 28's severe weight loss until July 2, 2025. Interview with Employee 1 on July 9, 2025, at 2:22 PM confirmed these findings for Resident 28. Employee 1 stated that she did not believe the June 1 and June 2 weights were accurate; therefore, she crossed them out. Employee 1 confirmed she did not obtain a reweight or implement any interventions in June 2025, because she felt the weights were inaccurate. Employee 1 confirmed there was no documentation of any attempts to reweigh Resident 28 until July 2, 2025. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0692		
F 0695 SS=D		F 0695		

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F 0695 SS=D	Continued from page 40 483.25(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	The facility reviewed the orders in relation to the continued oxygen rate for resident#23 and corrective actions were taken. There was no evidence of any ill effect on these residents. A review of the orders for any residents with the diagnosis of chronic obstructive pulmonary disease and COPD with exacerbation were reviewed and any variances from the order were corrected and noted in the charts. Education was provided by the Director of Nursing or designee on the adherence to the written order for oxygen and the adherence to the facility policy. Audits will be completed on 5 charts weekly for one month and biweekly for 3 months relating to the appropriate management of respiratory care, in particular the monitoring of oxygen levels. Findings will be presented to the	Completion Date: **08/19/2025** Status: **APPROVED** Date: **08/01/2025**

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 0695 SS=D	Continued from page 41	F 0695	Quality Assurance Performance Improvement committee for recommendations, an explanation of any identified variance infractions.	

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F 0695 SS=D	Continued from page 42 Based on observation, clinical record review, and staff interview, it was determined that the facility failed to provide appropriate respiratory care and services for one of one resident reviewed (Residents 23). Findings include: Clinical record review revealed the facility admitted Resident 23 on December 26, 2019, with a diagnose of chronic obstructive pulmonary disease with (acute) exacerbation added on October 12, 2023. Observation of Resident 23 on July 8, 2025, at 10:50 AM and 1:25 PM revealed he was in his wheelchair with a nasal cannula (NC, tubing to deliver oxygen to the nose) on and running at 2.5 liters per minute (LPM). Observation of Resident 23 on July 9, 2025, at 10:53 AM revealed Resident 22 was in his wheelchair with oxygen on and running at 2.5 LPM.	F 0695		

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F 0695 SS=D	Continued from page 43 Review of Resident 23s physician orders revealed a current order for staff to administer Resident 23 oxygen continuous every shift at 1.5 liters via nasal canula. The findings were reviewed with the Nursing Home Administrator and Director of Nursing on July 9, 2025, at 12:00 PM. 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0695		
F 0699 SS=D		F 0699		

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F 0699 SS=D	Continued from page 44 483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by:	F 0699	Staff completed a review of resident #59's medical record to identify triggers related to the resident's diagnosis of PTSD (Post Traumatic Stress Disorder). An updated care plan was completed by social services to provide individualized care. A review of current residents with the diagnosis of PTSD has been completed. Any findings were addressed with a revised care plan to include potential triggers relating to the resident's diagnosis that may retraumatize the resident. Education was provided by the director of nursing or designee to the clinical and nursing management staff on the basis of identifying potential triggers for residents with the diagnosis of PTSD and the proper annotation within the care plans. Audits will be completed on 5 charts weekly for one month and biweekly for 3 months relating to the residents	Completion Date: **08/19/2025** Status: **APPROVED** Date: **08/01/2025**

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F 0699 SS=D	Continued from page 45	F 0699	with diagnosis of PTSDS and ensure the care plan has been appropriately annotated. Findings will be presented to the Quality Assurance Performance Improvement committee for recommendations, an explanation of any identified variance infractions.	

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F 0699 SS=D	Continued from page 46 Based on clinical record review and resident and staff interview, it was determined that the facility failed to identify triggers related to a resident's diagnosis of Post-Traumatic Stress Disorder (PTSD), to provide culturally, competent, trauma-informed care, and to eliminate or mitigate re-traumatization for one of five residents reviewed for mood/behavior (Resident 59). Findings include: Clinical record review for Resident 59 revealed that the facility admitted him with a diagnosis of PTSD (PTSD, a mental and behavioral disorder that develops related to a terrifying event), on April 30, 2024. Interview with Resident 59 on July 9, 2025, at 8:45 AM revealed that he has PTSD that is triggered by loud noises, and other people screaming in the middle of the night. He said the screaming startles him and he wakes up panicked wondering what had happened.	F 0699		

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F 0699 SS=D	Continued from page 47 Further review of Resident 59's care plan revealed no evidence that the facility identified triggers (everyday situations that cause a person to re-experience the traumatic event as if it was reoccurring) for him related to his diagnosis of PTSD. Resident 59's clinical record contained no evidence the facility collaborated with the resident, and as appropriate, the resident's family, friends, and any other healthcare professionals (such as psychologists, and mental health professionals) to develop and implement individualized interventions. These findings were reviewed with the Nursing Home Administrator and Director of Nursing on July 9, 2025, at 12:20 PM. 28 Pa Code 211.12 (d)(3)(5) Nursing services	F 0699		
F 0730 SS=E		F 0730		

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F 0730 SS=E	Continued from page 48 483.35(e)(7) Nurse Aide Peform Review-12 hr/yr In-Service §483.35(e)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:	F 0730	No evidence of any actual ill effect exists on any residence in our community due to the lack of adherence to the requirements of completion of performance evaluations for staff members identified as #7, 8, and 9. Performance evaluations were completed on these staff members to ensure they meet such requirements. Performance evaluations are being conducted/completed on the current CNA staff. Information on a deficiency basis on these evaluations will be utilized for future training purposes. In addition, performance evaluations will be scheduled with staff on their original anniversary date. Management staff have been educated about the need for annual performance evaluations, and a system of tracking and scheduling is created to ensure human resources send out monthly reminders of those required.	Completion Date: **08/19/2025** Status: **APPROVED** Date: **08/01/2025**

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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 0730 SS=E	Continued from page 49	F 0730	A tracking tool will be reviewed monthly for six months to ensure performance evaluations are completed and filed in the individual staff records. Findings will be presented to the Quality Assurance Performance Improvement committee for recommendations, an explanation of any identified variance infractions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395533	A. BLDG: 00 B. WING:	07/10/2025

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F 0730 SS=E	Continued from page 50 Based on employee personnel record review and staff interview, it was determined that the facility failed to complete a performance evaluation of each nurse aide at least once every 12 months for three of three nurse aides reviewed (Employees 7, 8, and 9). Findings include: The facility noted the following hire dates for three employees reviewed for performance evaluations (EPR, employee performance review): Employee 7's hire date of November 5, 1991, last EPR was November 14, 2023. Employee 8's hire date of June 24, 1996, last EPR was May 26, 2024. Employee 9's hire date of October 31, 2017, last EPR was October 18, 2023. A request to review the annual performance evaluations revealed no documented evidence that	F 0730		

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F 0730 SS=E	Continued from page 51 the facility completed performance evaluations for Employees 7, 8, and 9 (nurse aides) at least once every 12 months. Interview with the Nursing Home Administrator on July 10, 2025, at 9:40 AM confirmed that performance evaluations were not completed annually on the three employees requested. 28 Pa. Code 201.19 (2) Personnel policies and procedures	F 0730		
F 0744 SS=E		F 0744		

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F 0744 SS=E	Continued from page 52 483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by:	F 0744	Newly completed individualized dementia care plans were developed for residents #33, #52 and #61 by the facility's social worker. No evidence of any actual ill effect exists on any of the residents in our community due to the lack of adherence to the requirements of said individualized care plans. A review of the residents admitted within the past 6 (six) months was conducted to ensure all residents with a current diagnosis of dementia have individualized care plans in place. Future admissions or residents with newly diagnosed dementia will have a new care plan completed within 72 hours. An education session was completed by the director of nursing or designee with social services on the importance of accuracy of diagnosis on care plans and ensuring that they are individualized to each resident. Audits will be completed on 5 charts	Completion Date: **08/19/2025** Status: **APPROVED** Date: **08/01/2025**

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 0744 SS=E	Continued from page 53	F 0744	weekly for one month and biweekly for 3 months relating to the residents with diagnosis of dementia and ensure the care plan has been appropriately annotated. Findings will be presented to the Quality Assurance Performance Improvement committee for recommendations, an explanation of any identified variance infractions.	

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F 0744 SS=E	Continued from page 54 Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement an individualized person-centered care plan to address dementia and cognitive loss displayed by three of five residents reviewed (Residents 33, 52, and 61). Findings include: Clinical record review for Resident 33 revealed the facility admitted her on March 26, 2025, with diagnosis including Dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life). A review of Resident 33's admission Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated March 31, 2025, indicated that the facility assessed Resident 33 as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed.	F 0744		

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F 0744 SS=E	Continued from page 55 A review of Resident 33's care plan revealed that there was no indication that the facility had developed and implemented a person-centered care plan to address the resident's dementia and cognitive loss. The findings were reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on July 9, at 2:30 PM. On July 10, 2025, at 10:00 AM the Director of Nursing confirmed the facility had no further documentation that the facility developed and implemented an individualized person-centered care plan to address Resident 33's dementia. Clinical record review for Resident 52 revealed the facility admitted her on June 11, 2025, with diagnoses including dementia. A review of Resident 52's MDS, dated June 17, 2025, indicated that the facility assessed Resident 52 as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed.	F 0744		

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F 0744 SS=E	Continued from page 56 A review of Resident 52's care plan revealed that there was no indication that the facility had developed and implemented a person-centered care plan to address the resident's dementia and cognitive loss. The findings were reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on July 9, 2025, at 12:05 PM. On July 10, 2025, at 10:23 AM the Nursing Home Administrator confirmed the facility had no further documentation that the facility developed and implemented an individualized person-centered care plan to address Resident 52's dementia prior to surveyor's questioning. Review of Resident 61's clinical record revealed that the facility admitted her on March 20, 2024, with a diagnosis of Dementia. Review of Resident 61's admission MDS dated March 27, 2025, indicated that the facility assessed	F 0744		

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F 0744 SS=E	Continued from page 57 Resident 61 as having a diagnosis of Dementia and that the facility would develop a care plan for dementia and cognitive loss. A review of Resident 61's care plan revealed that there was no indication the facility developed an individualized person-centered plan of care to address her dementia and cognitive loss, which should reflect family involvement in development. Interview with Employee 4, social worker, on July 10, 2025, at 10:24 AM confirmed the above findings for Resident 61, and indicated that the individualized dementia care plan for Resident 61 was developed after the concerns were discussed by the surveyor. 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services	F 0744		
F 0756 SS=D		F 0756		

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F 0756 SS=D	Continued from page 58 483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 0756	No evidence of any actual ill effect exists on any of the residents in our community due to lack of adherence to the requirements of monthly medication regimen review. Resident #65's medications have been reviewed and will be reviewed going forward by the facility's new pharmacy consultant. The facility's current new pharmacy consultant has assured us that they will complete the residents' medication regimen is reviewed monthly. The first consultant report was provided on July 21st. An educational session was conducted by the Director of Nursing or designee with nursing staff on the importance of ensuring all residents have monthly medication regimen reviews by a pharmacy consultant. Audits of the Drug Regimen reviews will be completed monthly for 6 months, and any deficiencies will be addressed immediately and reported	Completion Date: **08/19/2025** Status: **APPROVED** Date: **08/01/2025**

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F 0756 SS=D	Continued from page 59 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 0756	to the Director of Nursing for corrective action. Findings will be presented to the Quality Assurance Performance Improvement committee for recommendations, an explanation of any identified variance infractions.	

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F 0756 SS=D	Continued from page 60 Based on clinical record review and staff interview, it was determined that the facility failed to ensure a consultant pharmacist reviewed a residents medication regimen monthly for one of five residents reviewed for potentially unnecessary medications (Resident 65). Findings include: Clinical record review for Resident 65 revealed that the resident was admitted on April 7, 2025. Clinical record review for Resident 65 revealed a diagnosis list that included Alzheimers Disease (a brain disorder that affects memory, thinking, and cognitive abilities), cognitive impairment, and anxiety. Review of facility documentation for Resident 65 revealed a monthly medication regimen review dated April 10, 2025, from the consultant pharmacist. Further clinical record review for Resident 65	F 0756		

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F 0756 SS=D	Continued from page 61 revealed no documentation that a licensed pharmacist completed required monthly medication regimen reviews for the resident during May and June 2025. Documentation for the completed monthly medication reviews was requested by the surveyor during meetings with the Nursing Home Administrator and Director of Nursing on July 8, 2025, at 2:10 PM and July 9, 2025, at 2:00 PM. An interview with the Director of Nursing on July 10, 2025, at 12:59 PM confirmed there was no further documentation to indicate that Resident 65s monthly medication regimen reviews were completed for May or June 2025. 28 Pa. Code 211.9 (k) Pharmacy services 28 Pa. Code 211.12(d)(3)(5) Nursing services	F 0756		
F 0791 SS=D		F 0791		

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F 0791 SS=D	Continued from page 62 483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;	F 0791	The facility was unable to take actions for residents 23 due to the resident ceased to breath within the facility. A review of the residents potentially needing dental care services was completed. Upon identification of needs for such service was discussed with the provider and actions were taken to ensure that the resident was scheduled and/or received dental care. Education was provided by the director of nursing and/or designee to clinical staff and our scheduling team on the importance of residents being offered dental services either within the facility or outside to their personal dentist. Audits will be completed weekly for one month and bi-weekly for an additional three months focusing on the identification of resident's needing service and being scheduled for dental care. Any findings will be reported to our	Completion Date: **08/19/2025** Status: **APPROVED** Date: **08/01/2025**

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F 0791 SS=D	Continued from page 63 §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by:	F 0791	Quality Assurance Performance Improvement committee for further discussion.	

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F 0791 SS=D	Continued from page 64 Based on clinical record review, observation, and staff and resident interview, it was determined that the facility failed to assist a resident to obtain routine dental care for one of one resident reviewed for dental concerns (Resident 23). Findings include: Observation and interview with Resident 23 on July 8, 2025, at 10:55 AM revealed he had several missing and broken bottom teeth. Resident 23 stated that he does not remember the last time he was offered dental services. Clinical record review revealed the facility admitted Resident 23 on December 26, 2019, with payment sources that included the state Medicaid benefit. Review of Resident 23s clinical record revealed a physicians order for a dental consult and follow up as needed on January 1, 2025. Further review of Resident 23s clinical record revealed his last dental visit was August 21, 2024.	F 0791		

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F 0791 SS=D	Continued from page 65 Interview with the Director of Nursing on July 10, 2025, at 10:19 AM confirmed Resident 23 did not receive dental care according to state plan. The facility failed to provide evidence that Resident 23 received routine prophylactic dental cleanings as covered under the State plan. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0791		
F 0812 SS=E		F 0812		

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F 0812 SS=E	Continued from page 66 483.60(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	The facility dietary department conducted a thorough cleaning of the entire department to include the dry storage area and under the walk-in freezer fan. In addition, all areas such as the freezer, refrigerators, coolers and storage areas were inspected, and any corrections needed to labels, etc. were made at that time. No action could be taken on the failure to document the tray line food temperatures. The expandable dough cutter was removed and disposed of. If needed, a new cutter will be ordered for use in the kitchen. Corrective actions were taken in the areas identified, and education was provided at a mandatory meeting with staff to address the importance and necessity of proper cleaning techniques. In addition, the session included the sanitary and safe operations of the kitchen to include all documentation requirements and temperature recordings. Audits of the kitchen area's	Completion Date: **08/19/2025** Status: **APPROVED** Date: **08/01/2025**

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 0812 SS=E	Continued from page 67	F 0812	cleanliness, documentation requirements, proper labeling of food items and temperature control recording will be conducted twice a week for 2 (two) weeks, bi-weekly for one month and monthly for 2 (two) months. Findings will be presented and discussed at the Quality Assurance Performance Improvement Committee.	

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F 0812 SS=E	Continued from page 68 Based on observation and staff interview, it was determined that the facility failed to store food items in a safe and sanitary manner, maintain equipment in a sanitary condition, and prepare food items in accordance with professional standards in the facility's main kitchen. Findings include: Initial tour of the facility's main kitchen with Employee 6, Director of Dining Services, on July 8, 2025, at 10:00 AM revealed the following: A walk-in freezer contained a cardboard box with several items packaged in slide lock plastic bags. One bag contained baked beans with no label or dates. The other bag contained peeled, whole bananas with no label or dates. A concurrent interview with Employee 6 revealed it was unclear on when the items were packaged or the use by date. The top shelf of a storage unit located under the	F 0812		

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F 0812 SS=E	Continued from page 69 circulating fans in the walk-in freezer contained several packages of sliced flavored bread. There was a significant accumulation of ice on three of the bread packages. The dry goods storage area contained metal shelving units on wheels. The floor under four of the observed shelves contained a significant accumulation of debris that included dust, unopened eight-ounce soda cans, and various debris (discarded paper products, a condiment packet, a single-use butter packet, and several plastic spoons). A shelf in the kitchen contained two partially used vinegar containers with no open date and a partially used container of syrup with no open date on it. An expandable dough cutter located in a drawer had an extensive build-up of a batter-like substance and multiple areas of rust. The above information was reviewed in a meeting	F 0812		

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F 0812 SS=E	Continued from page 70 with the Nursing Home Administrator and Director of Nursing on July 8, 2025, at 2:10 PM. A review of tray line food temperature logs on July 9, 2025, at 11:48 AM revealed no documented dinner temperatures for the following dates: May 1, 11, 13, 14, and 18, 2025 June 18, 22, 25, and 26, 2025 An interview with Employee 6 on July 9, 2025, at 11:50 AM revealed that tray line food temperatures should be documented for each meal service. Employee 6 further noted it was unclear why the dinner food temperatures were not documented for the above dates. This information regarding the food temperatures was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on July 9, 2025, at 12:00 PM. 483.60(i) Food prepare, distribute, and serve	F 0812		

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F 0812 SS=E	Continued from page 71 -sanitary/safety Previously cited 8/2/24 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.14(a) Responsibility of licensee	F 0812		
F 0814 SS=C		F 0814		

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F 0814 SS=C	Continued from page 72 483.60(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	Upon identification of the deficient practice, the facility's maintenance department cleaned and sanitized the area surrounding the main dumpster. All visible debris, trash, and waste (e.g., gloves, hairnets) were properly disposed of. The standing water was removed from the generator's fuel containment area, and all exposed nails were removed from the fencing. Residents did not have direct access to this area and were not directly affected. Staff education was completed on July 22, 2025, for dietary, maintenance, and housekeeping departments regarding proper waste disposal procedures, environmental hazard identification, and reporting procedures for unsafe conditions. Weekly environmental inspections/audits of the dumpster area will be completed for one month and bi-weekly for 3 months. All findings will be reported to the Quality Assurance and Performance	Completion Date: **08/19/2025** Status: **APPROVED** Date: **08/01/2025**

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F 0814 SS=C	Continued from page 73	F 0814	Improvement (QAPI) Committee. The QAPI Committee will review trends and recommend corrective actions if future deficiencies are identified.	

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F 0814 SS=C	Continued from page 74 Based on observation and staff interview, it was determined that the facility failed to properly contain and dispose of garbage in the facility's main dumpster area. Findings include: Observation of the facility's main dumpsters on July 8, 2025, at 10:45 AM, located outside of a rear egress door from the facilitys main kitchen revealed the following: There was debris and garbage on the ground surrounding the dumpster that included the following: four feet tall weeds, one to two inches of stagnant water ponding in a metal containment area underneath the container that held the facilitys generator fuel supply, seven wooden boards of a fence that surrounded the dumpster area that each contained three rusted nails (for a total of 21) protruding from the boards and posing a risk of injury, an accumulation of dead leaves, discarded cardboard, and various discarded items on the	F 0814		

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F 0814 SS=C	Continued from page 75 ground (hair nets, gloves, paper products, and pieces of wood). The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on July 8, 2025, at 2:10 PM. 28 Pa. Code 201.14(a) Responsibility of licensee	F 0814		
F 0883 SS=E		F 0883		

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F 0883 SS=E	Continued from page 76 483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 0883	Residents 11, 18, 19 and 29 (or their resident representative) have been contacted by the facilities medical records representative and provided education and handouts as well as offering the updated vaccine. As the resident or representative's decision is conveyed, the outcome was/will be annotated in the medical chart on the Pneumococcal Consent, in the administration record and under the immunization tab in each resident's chart. Resident #23 has ceased to breathe July 21, 2025. A facility audit was completed on 7/22/25 to identify all residents who are due Pneumococcal Immunization. Residents due the vaccine will be offered a Prevnar 20 per the recommendation of the Medical Director. Resident education will be provided with each resident's consent. Education was provided to clinical staff, and the admissions director ensuring they are familiar with and aware of the Prevnar 20 vaccine and	Completion Date: **08/19/2025** Status: **APPROVED** Date: **08/01/2025**

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F 0883 SS=E	Continued from page 77 (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:	F 0883	the need to offer the vaccine to incoming resident or their responsible party. Weekly audits will be conducted for one month and bi-weekly for three months on all new residents to assure compliance with the requirements set forth in the vaccine program. Findings will be presented to the Quality Assurance Performance Improvement committee for recommendations, an explanation of any identified variance infractions.	

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F 0883 SS=E	Continued from page 78 Based on clinical record review, review of select facility policies and procedures, and staff interview, it was determined that the facility failed to offer recommended pneumococcal immunizations for five of five residents reviewed for immunizations (Resident 11, 18, 19, 23 and 29). Findings include: The policy entitled "Pneumococcal Vaccine, last reviewed February 26, 2025, indicates that prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine, and when indicated, will be offered the vaccine within 30 days of admission. Administration of the pneumococcal vaccines or revaccinations will be made in accordance with the current CDC (Center for Disease Control and Prevention) recommendations at the time of the vaccinations. Review of Resident 11s clinical record revealed that the facility admitted her on January 28, 2021. Documentation in Resident 11s clinical record	F 0883		

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F 0883 SS=E	Continued from page 79 revealed that she received a pneumococcal vaccine (Prevnar 13) prior to her admission in 2016, and the PPSV23 in 2001. According to the CDC guidance entitled Pneumococcal Vaccination Timing dated October 2024, the facility is to decide together with the resident, if the resident would like an updated pneumococcal vaccine. There was no documented evidence to indicate that the facility offered Resident 11 an updated pneumococcal vaccination. Review of Resident 18s clinical record revealed that the facility admitted her on March 6, 2023. Documentation in Resident 18s clinical record revealed that she received a pneumococcal vaccine (Prevnar 13) prior to her admission in 2015, and the PPSV23 in 2008. According to the CDC guidance entitled Pneumococcal Vaccination Timing dated October 2024, the facility is to decide together with the resident, if the resident would like an updated pneumococcal vaccine.	F 0883		

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F 0883 SS=E	Continued from page 80 There was no documented evidence to indicate that the facility offered Resident 18 an updated pneumococcal vaccination. Review of Resident 19s clinical record revealed that the facility admitted him on July 23, 2022. Documentation in Resident 19s clinical record revealed that he received a pneumococcal vaccine (Prevnar 13) prior to his admission in 2022. According to the CDC guidance entitled Pneumococcal Vaccination Timing dated October 2024, Resident 19s pneumococcal vaccinations would not be complete until he received a PCV20 or PCV21 one year after he received his Prevnar 13. There was no documented evidence to indicate that the facility offered Resident 19 an updated pneumococcal vaccination. Review of Resident 23s clinical record revealed that the facility admitted him on December 26, 2019. Documentation in Resident 23s clinical record	F 0883		

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F 0883 SS=E	Continued from page 81 revealed that he received a pneumococcal vaccine (Prevnar 13) prior to his admission in 2015, and the PPSV23 in 2011. According to the CDC guidance entitled Pneumococcal Vaccination Timing dated October 2024, the facility is to decide together with the resident, if the resident would like an updated pneumococcal vaccine. There was no documented evidence to indicate that the facility offered Resident 23 an updated pneumococcal vaccination. Review of Resident 29s clinical record revealed that the facility admitted her on October 29, 2019. Documentation in Resident 29s clinical record revealed that she received a pneumococcal vaccine (Prevnar 13) prior to her admission in 2018, and the PPSV23 in 2018. According to the CDC guidance entitled Pneumococcal Vaccination Timing dated October 2024, the facility is to decide together with the resident, if the resident would like an updated pneumococcal vaccine.	F 0883		

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F 0883 SS=E	Continued from page 82 There was no documented evidence to indicate that the facility offered Resident 29 an updated pneumococcal vaccination. 483.80(d) Influenza and Pneumococcal Immunizations Previously cited 8/2/24 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0883		
F 0947 SS=E		F 0947		

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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 0947 SS=E	Continued from page 83 483.95(g)(1)-(4) Required In-Service Training for Nurse Aides §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by:	F 0947	There is no evidence of any actual ill effect on any residence in our community due to the lack of adherence to the requirements of in-service training for nurse aides and staff within the facility. Staff 7, 8, and 9 were provided with additional training to meet this requirement. Upon review of the CNA records, those needing documented training were scheduled for the upcoming (monthly) "Annual Training" session, and each were provided additional training to ensure they received the requirement to meet the regulatory guidelines. Education was provided to the Human Resource Rep on the requirement for and adherence to the Inservice Training requirements. Monitoring of this requirement will be conducted by use of an audit to include monthly file reviews for the CNAs annual training as well as new employees being scheduled in accordance with their hire date for a	Completion Date: **08/19/2025** Status: **APPROVED** Date: **08/01/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395533	A. BLDG: __00_____ B. WING: _____	07/10/2025

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F 0947 SS=E	Continued from page 84	F 0947	six-month period. The newly appointed ADON will also be assisting in the monitoring of this requirement. Findings will be presented to the Quality Assurance Performance Improvement committee for recommendations, an explanation of any identified variance infractions.	

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F 0947 SS=E	Continued from page 85 Based on review of employee education records and staff interview, it was determined that the facility failed to ensure that nurse aides received 12 hours of in-service training annually for three of three nurse aides reviewed (Employees 7, 8, and 9). Findings include: During a meeting with the Nursing Home Administrator and Director of Nursing on July 8, 2025, at 2:00 PM the surveyor asked for training records to indicate that nurse aides had received at least 12 hours of in-service training in the last year for Employees 7, 8, and 9 (nurse aides). Interview with the Nursing Home Administrator and Director of Nursing on July 10, 2025, at 10:05 AM confirmed there was no documented evidence that the above employees received the required 12 hours of annual in-service training. 28 Pa. Code 201.19 (7) Personnel policies and procedures	F 0947		

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F 0947 SS=E	Continued from page 86 28 Pa. Code 201.20(a)(6)(d) Staff development	F 0947		

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P 1210		P 1210		

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 1210	Continued from page 1 Management. (2) Protection of personal and property rights of the residents, while in the facility, and upon discharge or after death, including the return of any personal property remaining at the facility within 30 days after discharge or death. This REGULATION is not met as evidenced by:	P 1210	A search of the storage areas in which resident belongings are secured until picked up by family members was conducted and there was no evidence of any belongings of identified residents #82 or 83. The facility has implemented a new inventory of personal effects forms that will be completed by the nursing department upon admission. Education provided to clinical staff on the proper documentation of the personal properties/belongings of newly admitted residents. Included in the education is the process for logging and updating to the form as additional items are provided to the residents. Explanation of the appropriate actions to take upon discharge or death will be included in the education. Audits of newly admitted residents' inventory sheets will be completed on a weekly basis for one month and bi-weekly for 3 months.	Completion Date: **08/19/2025** Status: **APPROVED** Date: **08/01/2025**

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P 1210	Continued from page 2	P 1210	Findings will be presented to the Quality Assurance Performance Improvement committee for recommendations, an explanation of any identified variance infractions.	

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P 1210	Continued from page 3 Based on closed clinical record review and staff interview, it was determined that there was no evidence that identified the disposition of a resident's personal belongings following discharge from the facility for two of three closed records reviewed (Residents 82 and 83). Findings include: Closed clinical record review revealed the facility admitted Resident 82 on May 29, 2025. There was no documented evidence to indicate what personal belongings Resident 82 brought to the facility on admission. There was no documented evidence to indicate that the facility accounted for any personal belongings upon Resident 82s discharge on June 1, 2025. Interview with the Director of Nursing on July 10, 2025, at 10:56 AM confirmed the above noted findings related to the disposition of Resident 82's personal belongings.	P 1210		

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P 1210	Continued from page 4 Closed clinical record review revealed the facility admitted Resident 83 on February 7, 2025. There was no documented evidence to indicate what personal belongings Resident 83 brought to the facility on admission. There was no documented evidence to indicate that the facility accounted for any personal belongings upon Resident 83s discharge on May 27, 2025. Interview with the Director of Nursing on July 10, 2025, at 9:48 AM confirmed the above noted findings related to the disposition of Resident 83's personal belongings.	P 1210		
P 4880		P 4880		

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 4880	Continued from page 5 Medical records. (f) In addition to the items required under 42 CFR 483.70(i)(5) (relating to administration), a resident ' s medical record shall include at a minimum: (i) Physicians' orders. (ii) Observation and progress notes. (iii) Nurses' notes. (iv) Medical and nursing history and physical examination reports. (v) Admission data. (vi) Hospital diagnoses authentication. (vii) Report from attending physician or transfer form. (vii) Diagnostic and therapeutic orders. (viii) Reports of treatments. (ix) Clinical findings. (x) Medication records. (xi) Discharge summary, including final diagnosis and prognosis or cause of death. This REGULATION is not met as evidenced by:	P 4880	The need for a discharge summary was reviewed and the provider(s) completed a summary for both Resident #82 and #83. The discharge summary form was updated and provided to the nursing staff to be utilized for all residents being discharged under the supervision of consultant physician, and all resident deaths under the supervision of the medical director and her PA for the purpose of providing the final diagnosis. The Medical Director and her PA provide a detailed discharge note with discharges that provides all of the information required per regulatory guidelines. Education was provided to licensed clinical nursing staff as to how and when the discharge summary should be utilized in accordance with facility discharge policy. Auditing will occur with a review of all discharges on a weekly basis for one month and bi-weekly for three	Completion Date: **08/19/2025** Status: **APPROVED** Date: **08/01/2025**

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P 4880	Continued from page 6	P 4880	months. Findings will be presented to the Quality Assurance Performance Improvement committee for recommendations, an explanation of any identified variance infractions.	

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P 4880	Continued from page 7 Based on clinical record review and staff interview, it was determined that the facility failed to ensure completion of a discharge summary for two of three discharged residents reviewed (Resident 82 and 83). Findings Include: Clinical record review for Resident 82 revealed that the resident was admitted on May 29, 2025, and signed out against medical advice from the facility on June 1, 2025. Resident 82's closed clinical record did not contain a discharge summary to include a summary of stay or final diagnosis. Interview with the Director of Nursing on July 10, 2025, at 10:56 AM confirmed these findings. Clinical record review for Resident 83 revealed that the resident was admitted to the facility on February 7, 2025, and was sent to the hospital on May 20, 2025, due to a fall and change in her condition. Resident 83 did not return to the facility and was	P 4880		

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P 4880	Continued from page 8 discharged on May 27, 2025. Resident 83's closed clinical record did not contain a discharge summary to include a summary of her stay or final diagnosis. Interview with the Director of Nursing on July 10, 2025, at 9:48 AM confirmed these findings.	P 4880		
P 5280		P 5280		

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P 5280	Continued from page 9 Pharmacy services. (j.1) The facility shall have written policies and procedures for the disposition of medications that address all of the following: (1) Timely and safe identification and removal of medications for disposition. (2) Identification of storage methods for medications awaiting final disposition. (3) Control and accountability of medications awaiting final disposition consistent with standards of practice. (4) Documentation of actual disposition of medications to include the name of the individual disposing of the medication, the name of the resident, the name of the medication, the strength of the medication, the prescription number if applicable, the quantity of medication and the date of disposition. (5) A method of disposition to prevent diversion or accidental exposure consistent with applicable Federal and State requirements, local ordinances and standards of practice. This REGULATION is not met as evidenced by:	P 5280	Attempts were made to obtain documented evidence that a disposition of resident #82's medication was completed; however, it was unsuccessful. Education was provided to all registered nurses and licensed practical nurses, conducted by the director of nursing on the implementation of the disposition of medications at the time of discharge. Auditing will be completed with a review of all discharges on a weekly basis for one month and bi-weekly for three months. Findings will be presented to the Quality Assurance Performance Improvement committee for recommendations, an explanation of any identified variance infractions.	Completion Date: **08/19/2025** Status: **APPROVED** Date: **08/01/2025**

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P 5280	Continued from page 10 Based on closed clinical record review and staff interview, it was determined that the facility failed to document the accounting and disposition of medications in the clinical record upon discharge of one of three residents reviewed (Resident 82). Findings include: Clinical record review for Resident 82 revealed that she signed out of the facility against medical advice on June 1, 2025. There was no documented evidence in Resident 82's closed clinical record regarding the disposition of the following medications: Atorvastatin (helps lower cholesterol) 20 mg (milligrams), Diltiazem (treats high blood pressure) 120 mg, Methimazole (high thyroid) 5 mg, Mirtazapine (treats depression) 7.5 mg, and Lasix (for edema) 20 mg. Interview with the Director of Nursing on July 10, 202, at 10:56 AM confirmed that the facility was unable to provide documented evidence of	P 5280		

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P 5280	Continued from page 11 appropriate disposition of Resident 82's medications upon her discharge.	P 5280		
P 5520		P 5520		

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P 5520	Continued from page 12 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	There is no evidence of any ill effect on any residents within the community due to lack of adherence to the ratio requirement for the CNA staff on the dates indicated. Current CNA ratios are presented and reviewed at the morning leadership meeting to assure compliance in accordance with the daily DOH Staffing Hours report. Identified concerns are highlighted and discussed with management for additional planning purposes. Outliers are addressed for resolution of the current daily needs. Upon identification of continued staffing needs, immediate mass texts are sent to all current staff including fulltime, part time and PRN. In addition, needs are posted on agency sites and one-on-one conversations are held with staff to ensure staff needs are met. If continued needs exist, the group will touch base again mid-day to ensure corrective actions have been taken. Also, during the meeting, the following 3 days are reviewed to highlight any potential	Completion Date: **08/19/2025** Status: **APPROVED** Date: **08/01/2025**

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P 5520	Continued from page 13	P 5520	upcoming outlier concerns. An audit of the DOH Staffing Hour Calculator Report will be reviewed daily for two weeks and weekly for one month at the morning meeting for presentation and discussion of any variances with the established compliance requirements and actions taken to attempt to eliminate any variances. Findings will be presented to the Quality Assurance Performance Improvement committee for recommendations and explanation of any identified variance infractions.	

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P 5520	Continued from page 14 Based on a review of nursing staffing hours and staff interview, it was determined that the facility failed to ensure a minimum of one nurse aide (NA) per 10 residents during the day shift for seven of the 21 days reviewed, failed to ensure a minimum of one NA per 11 residents during the evening shift for two of the 21 days reviewed, and failed to ensure a minimum of one NA per 15 residents during the overnight shift for one of the 21 days reviewed. Findings include: Review of nursing staff care hours provided by the facility for April 6 to 12, 2025, May 25 to 31, 2025, and July 3 to 9, 2025, revealed the following NAs scheduled for the resident census: Day shift (requires one NA per 10 residents): April 7, 2025, 8.17 NAs for a census of 82, required 8.20 April 11, 2025, 7.83 NAs for a census of 87, required 8.70	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395533	A. BLDG: __00_____ B. WING: _____	07/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HERITAGE RIDGE SENIOR LIVING AT WINDY HILL STATE LICENSE NUMBER: **164302**	**100 DOGWOOD DRIVE PHILIPSBURG, PA 16866**

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P 5520	Continued from page 15 May 25, 2025, 7.30 NAs for a census of 86, required 8.60 May 27, 2025, 7.20 NAs for a census of 86, required 8.60 May 28, 2025, 8.30 NAs for a census of 86, required 8.60 July 5, 2025, 7.53 NAs for a census of 85, required 8.50 July 6, 2025, 7.87 NAs for a census of 86, required 8.60 Evening shift (requires one NA per 11 residents): April 11, 2025, 6.10 NAs for a census of 87, required 7.91 May 31, 2025, 7.33 NAs for a census of 89, required 8.09 Night shift (requires one NA per 15 residents):	P 5520		

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P 5520	Continued from page 16 April 7, 2025, 4.07 NAs for a census of 82, required 5.47 Interview with the Nursing Home Administrator and Director of Nursing on July 9, 2025, at 12:00 PM confirmed that the facility did not meet regulatory NA-to-resident ratios as evidenced above.	P 5520		
P 5530		P 5530		

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 5530	Continued from page 17 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	There is no evidence of any ill effect on any residents within the community due to lack of adherence to the ratio requirement for the LPN staff on these dates. Current LPN ratios are presented and reviewed at the morning leadership meeting to assure compliance in accordance with the daily DOH Staffing Hours report. Identified concerns are highlighted and discussed with management for additional planning purposes. Outliers are addressed for resolution of the current daily needs. Upon identification of continued staffing needs, immediate mass texts are sent to all current staff including fulltime, part time and PRN. In addition, needs are posted on agency sites and one-on-one conversations are held with staff to ensure staff needs are met. If continued needs exist, the group will touch base again mid-day to ensure corrective actions have been taken. Also, during the meeting, the following 3 days are reviewed to highlight any potential	Completion Date: **08/19/2025** Status: **APPROVED** Date: **08/01/2025**

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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P 5530	Continued from page 18	P 5530	upcoming outlier concerns. An audit of the DOH Staffing Hour Calculator Report will be reviewed daily for two weeks and weekly for one month at the morning meeting for presentation and discussion of any variances with the established compliance requirements and actions taken to attempt to eliminate any variances. Findings will be presented to the Quality Assurance Performance Improvement committee for recommendations, an explanation of any identified variance infractions.	

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 5530	Continued from page 19 Based on a review of nursing staffing hours and staff interview, it was determined that the facility failed to ensure a minimum of one licensed practical nurse (LPN) per 25 residents during the day shift for three of the 21 days reviewed, one LPN per 30 residents during the evening shifts on one of the 21 days reviewed, and one LPN per 40 residents during the overnight shift on one of the 21 days reviewed. Findings include: Review of nursing staff care hours provided by the facility for April 6 to 12, 2025, May 25 to 31, 2025, and July 3 to 9, 2025, revealed the following LPNs scheduled for the resident census: Day Shift (requires one LPN per 25 residents): May 28, 2025, 3.00 LPNs for a census of 86, required 3.44 LPNs May 31, 2025, 2.81 LPNs for a census of 89, required 3.56 LPNs	P 5530		

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P 5530	Continued from page 20 July 4, 2025, 3.00 LPNs for a census of 84, required 3.36 LPNs Evening shift (requires one LPN per 30 residents): May 30, 2025, 2.38 LPNs for a census of 88, required 2.93 LPNs Overnight shift (requires one LPN per 40 residents): May 30, 2025, 1.94 LPNS for a census of 88, required 2.20 LPNs Interview with the Nursing Home Administrator and Director of Nursing on July 9, 2025, at 12:00 PM confirmed that the facility did not meet regulatory LPN-to-resident ratios as evidenced above.	P 5530		
P 5640		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 21 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	There is no evidence of any ill effect on any residents within the community due to lack of adherence to the PPD requirement for staff on the eight dates indicated. Daily compliance to the PPDs is presented by the Human Resource representative during the morning leadership meeting for discussion and recommendations to ensure we are compliant with the required nursing care hours. Identified concerns are highlighted and discussed with management for planning purposes. Upon identification of continued staffing needs, immediate mass texts are sent to all current staff including fulltime, part time and PRN. In addition, needs are posted on agency sites and one-on-one conversations are held with staff to ensure staff needs are met. If continued needs exist, the group will touch base again mid-day to ensure corrective actions have been taken. Additional days are also reviewed for verification of the facility's adherence.	Completion Date: **08/19/2025** Status: **APPROVED** Date: **08/01/2025**

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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P 5640	Continued from page 22	P 5640	An audit of the DOH Staffing Hour Calculator Report will be reviewed daily for two weeks and weekly for one month at the morning meeting for presentation and discussion of any variances with the established compliance requirements and actions taken to attempt to eliminate any variances. Findings will be presented to the Quality Assurance Performance Improvement committee for recommendations, an explanation of any identified variance infractions.	

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P 5640	Continued from page 23 Based on review of nursing staffing hours and staff interview, it was determined that the facility failed to ensure the total of nursing care hours provided in each 24-hour period was a minimum of 3.2 hours per patient day (PPD), effective July 1, 2024, for 8 of 21 days reviewed. Findings include: Review of nursing staff care hours provided by the facility for April 6 through 12, 2025, May 25 to 31, 2025, and July 3 to 9, 2025, revealed that the facility failed to meet the minimum hours PPD for the following days: April 7, 2025, with 3.10 hours per resident per day. April 11, 2025, with 2.91 hours per resident per day. May 27, 2025, with 3.06 hours per resident per day. May 28, 2025, with 3.12 hours per resident per day.	P 5640		

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P 5640	Continued from page 24 May 30, 2025, with 2.99 hours per resident per day. May 31, 2025, with 2.94 hours per resident per day. July 5, 2025, with 3.00 hours per resident per day. July 7, 2025, with 3.02 hours per resident per day. Interview with the Nursing Home Administrator and Director of Nursing on July 9, 2025, at 12:00 PM confirmed that the facility failed to meet the required nursing staffing PPD as listed above.	P 5640		

Certified End Page

HERITAGE RIDGE SENIOR LIVING AT WINDY HILL

STATE LICENSE NUMBER: 164302

SURVEY EXIT DATE: 07/10/2025

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