PRINTED: 11/21/2025 FORM APPROVED 2567-L

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395721			00.	10/06/2025	
NAME OF PROVIDER OR SUPPLIER: PARAMOUNT NURSING AND REHABILITATION AT FAYETTEVILLE, LLC STATE LICENSE NUMBER: 420102			STREET ADDRESS, 6375 CHAMB! FAYETTEVII	ERSBURG	ROAD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE	OF DEFICIENCIES (EACH DEED BY FULL REGULATORY OF		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0000  F 0684  SS=J	Based on an abbreviate October 6, 2025, it was Nursing and Rehab at I compliance with the fo CFR Part 483, Subpart Term Care Facilities at Commonwealth of Pen Licensure Regulations.	s determined that Par Fayetteville, LLC, w llowing requirement B, Requirements fond the 28 PA Code, Insylvania Long Terr	ramount ras not in ts of 42 r Long m Care	F 0684	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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	OF DEFICIENCIES AND RRECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 395721			PLE CONSTRUCTION:	(X3) DATE SURV COMPLETED: 10/06/2025	EY
PARAMO	VIDER OR SUPPLIER: UNT NURSING AND REH ITEVILLE, LLC	ABILITATION	STREET ADDRESS, 6375 CHAMBI FAYETTEVII	ERSBURG	ROAD		
STATE LICENS	SE NUMBER: <b>420102</b>						
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG			(X5) COMPLETE DATE
F 0684	Continued from page 1			F 0684			
SS=J	483.25 Quality of Care  § 483.25 Quality of care Quality of care is a fundame treatment and care provided the comprehensive assessments ensure that residents reaccordance with professions comprehensive person-center residents' choices.  This REQUIREMENT is not	to facility residents. Ba ent of a resident, the fac- eceive treatment and car al standards of practice, ered care plan, and the	ised on ility e in		We were unable to correct deficiency F0684 related to 1 as resident expired in the fall nursing staff were educathe revised choking policy and symptoms to look for which choking. Employee 2 received on one education by Anthony Director of Nursing on Octo 10,2025 regarding CPR trainemphasis placed on choking and employee 2 demonstrate technique for the Heimlich maneuver. Employee 2 was on a Performance Improvem to demonstrate full knowledged demonstration of proper Heitechnique and adherence to emergency choking protocol Dysphagia/Choking Procedu in-service was provided to the by Anthony Clark, Director Nursing and Talayne Gates, Tuesday, October 14th at 7a and 3pm and will be held als Thursday, October 16th at 7a and 3pm for licensed staff an nursing assistants. DON revi	acility.  ted on nd signs hen ed one y Clark, ber hing and resident d proper  placed ent Plan ge, mlich  .  .  .  .  .  .  .  .  .  .  .  .  .	Completion Date: 10/31/2025 Status: APPROVED Date: 10/20/2025

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the emergency response for a

	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	Y
		395721		1	<u>ou</u>	10/06/2025	
PARAMOI AT FAYET	VIDER OR SUPPLIER: UNT NURSING AND REH TTEVILLE, LLC SE NUMBER: 420102	ABILITATION	STREET ADDRESS, 6375 CHAMBI FAYETTEVIL	ERSBURG	ROAD		
(X4) ID PREFIX TAG	PREFIX MUST BE PRECEEDED BY FULL REGULATORY O TAG IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE #	OULD BE	(X5) COMPLETE DATE
F 0684	Continued from page 2			F 0684			
SS=J					choking resident reviewed ty airway obstructions and how respond. SLP Dysphagia inreviewed diet textures, thicked liquids and general safe swall strategies. Direct In-service ton F0684 Quality of Care for licensed staff and nursing asswill be provided by Sophie CMSN, RN, CRRN, RAC-CTCNDLTC. Sophie Campbell Executive Director of the Pennsylvania Association of Directors of Nursing Adminiand is an approved directed in-service provider on the list he Department of Health. The directed staff in-service will on Wednesday, October 29th 1pm and 3pm. This in-service recorded for staff that is unal attend. Licensed staff unable attend the in-service will be to watch the recorded in-service prior to the start of their next Prior to starting the mock drior designee will conduct a ra audit of 5 employees underst of proper emergency procedure.	to service ened downing training r all sistants Campbell, , , l is the sistration tfrom the be held in at 7am, is evill be belt to ento required vice it shift.	

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	ΣΥ
		395721		B. WING: _	00	10/06/2025	
PARAMOI AT FAYET	VIDER OR SUPPLIER: UNT NURSING AND REH. ITEVILLE, LLC SE NUMBER: 420102	ABILITATION	STREET ADDRESS, 6375 CHAMB FAYETTEVII	ERSBURG	ROAD		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY CONTROL TAG IDENTIFYING INFORMATION)		ED BY FULL REGULATORY OF		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0684 SS=J	Continued from page 3			F 0684	choking resident's times one The results of this audit will reported at the October 23rd meeting and determined if for staff audits are needed. The will begin conducting quarte drills of emergency events in choking drill, code drill, eloq drill, and active shooter drill beginning in January 2026. results will be reviewed at th quarterly QAPI meetings. T	be QAPI urther Facility orly mock neluding pement The ne	
					committee will determine if frequent mock drills for eme events need to be held.		

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		395721		A. BLDG: _ B. WING: _	00	10/06/2025	
PARAMOU AT FAYET	VIDER OR SUPPLIER: UNT NURSING AND REH. TTEVILLE, LLC E NUMBER: 420102	ABILITATION	STREET ADDRESS, 6375 CHAMB FAYETTEVII	ERSBURG	ROAD		
(X4) ID PREFIX TAG	EFIX MUST BE PRECEEDED BY FULL REGULATORY OR LSC			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0684	Continued from page 4			F 0684			
SS=J	Based on clinical record review, select facility document review, policy review, review of diet guidelines and staff interviews, it was determined that the facility failed to ensure that care and services were provided in accordance with professional standards of practice to meet the needs of each resident for one of nine residents reviewed (Resident 1). This failure resulted in an Immediate Jeopardy situation for Resident 1 as evidenced by a delay in						
	provision of emergency death.	y services willen les	uned in				
	Findings include:						
	Review of facility policy, titled "Emergency Procedure-Choking," with a last review date of January 23, 2025, revealed the following, in part, "Trained staff will assist the resident which is choking by attempting to expel the foreign body from the airway. Conscious Resident-Standing or Sitting:1. Ask the resident if he or she is choking. Remember, a choking victim cannot speak or breathe and needs your help immediately. 4. Call for						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		395721		A. BLDG: _ B. WING: _		10/06/2025	
PARAMO AT FAYE	VIDER OR SUPPLIER: UNT NURSING AND REH ITEVILLE, LLC SE NUMBER: 420102	ABILITATION	STREET ADDRESS 6375 CHAME FAYETTEVI	BERSBURG	ROAD		
(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0684	Continued from page 5			F 0684			
SS=J	help, but stay with the cannot cough, only the performed as follows: Wrap your arms aroun Make a fist with one had of your fist against the mid-abdomen, below to navel. e. Grasp your classing the performed as follows:  A press your fist abdomen with a quick squeeze the ribcage. Conto your hands. h. Reperson body is expelled or the Unconscious Resident Unable to Reach Arour resident as gently as post the resident on his or hor her side. 4. Perform a. Facing the resident, resident's upper thighs heel of one hand on the mid-abdomen, below to navel with fingers points.	an should abdominal a. Stand behind reside the resident's wais and. d. Place the thuresident's upper the ribcage and abovenched fist with you into the resident's upward thrust. g. Do ontain the force of that the thrusts until the resident loses console. Lying Down (or Whad Resident): 1. East possible to the floor. So were back with the arm abdominal thrusts a kneel down and strawith your body. b. It is resident's upper the ribcage and above	thrusts be dent. b. t. c. mb side  e the ar other pper o not the thrust the foreign ciousness. then the the dent of the thrust the foreign ciousness. then the the dent of the thrust the foreign ciousness. then the thrust the foreign the foreign the thrust the foreign the				

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					(X3) DATE SURVEY COMPLETED: 10/06/2025	
TTEVILLE, LLC	ABILITATION	6375 CHAMB	ERSBURG	ROAD		
PREFIX MUST BE PRECEEDED BY FULL REGULATORY ( TAG IDENTIFYING INFORMATION)			ID PREFIX TAG	CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETE DATE
positioned hand. d. Bri over your hands. e. Use your hands into the res quick upward thrust. 5 maneuver to check for Keep the resident's factongue-jaw lift to open Moving the lower jaw throat and opens the air sweep using your index your index finger into of the cheek and across (2)Try to remove any for pushing foreign objects. Turn the resident's hear sweep an object from the four 4) and five (5) und Arrange for the resider physician immediately obstruction has been resider.	ng your shoulders for e your body weight to ident's upper abdom. Perform finger swe a foreign body as for e up. b. Perform the the resident's mouth moves the tongue of the resident's mouth at finger as a hook. (In the resident's mouth as the base of the tongue of the mouth. 6. Alternation the object is expellent to be evaluated by after the foreign body after the foreign body emoved. 7. If unable	orward to press en with a tep thous: a.  In (Note: If the e finger I) Insert alongside gue. Avoid bat. (4) ed to ate steps thed. a dy airway to clear	F 0684			
arrange emergency trai	nsport of the residen	t to the				
	vider or supplier:  UNT NURSING AND REH TEVILLE, LLC  ENUMBER: 420102  SUMMARY STATEMENT MUST BE PRECEEDI IDENTI  Continued from page 6  chest. c. Place the othe positioned hand. d. Bri over your hands. e. Us your hands into the res quick upward thrust. 5 maneuver to check for Keep the resident's fac tongue-jaw lift to open Moving the lower jaw throat and opens the ai sweep using your index your index finger into of the cheek and across (2)Try to remove any fi pushing foreign object. Turn the resident's hea sweep an object from to four 4) and five (5) und Arrange for the resider physician immediately obstruction has been re the foreign body from	VIDER OR SUPPLIER:  JINT NURSING AND REHABILITATION TEVILLE, LLC  E NUMBER: 420102  SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)  Continued from page 6  chest. c. Place the other hand directly over positioned hand. d. Bring your shoulders for over your hands. e. Use your body weight the your hands into the resident's upper abdom quick upward thrust. 5. Perform finger sweemaneuver to check for a foreign body as for Keep the resident's face up. b. Perform the tongue-jaw lift to open the resident's mouth Moving the lower jaw moves the tongue of throat and opens the airway.) c. Perform the sweep using your index finger as a hook. (  your index finger into the resident's mouth of the cheek and across the base of the tongue (2)Try to remove any foreign objects. (3) A pushing foreign objects deeper into the throat the resident's head to one side if need sweep an object from the mouth. 6. Alternate four 4) and five (5) until the object is expel Arrange for the resident to be evaluated by physician immediately after the foreign boo obstruction has been removed. 7. If unable the foreign body from obstructing the airway.	IDENTIFICATION NUMBER:  395721  STREET ADDRESS, 6375 CHAMB FAYETTEVIL E NUMBER: 420102  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued from page 6  chest. c. Place the other hand directly over the positioned hand. d. Bring your shoulders forward over your hands. e. Use your body weight to press your hands into the resident's upper abdomen with a quick upward thrust. 5. Perform finger sweep maneuver to check for a foreign body as follows: a.	A BLDG: 395721  STREET ADDRESS, CITY, STATE, 46375 CHAMBERSBURG FAYETTEVILLE, PA 17  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued from page 6  Chest. c. Place the other hand directly over the positioned hand. d. Bring your shoulders forward over your hands. e. Use your body weight to press your hands into the resident's upper abdomen with a quick upward thrust. 5. Perform finger sweep maneuver to check for a foreign body as follows: a. Keep the resident's face up. b. Perform the tongue-jaw lift to open the resident's mouth. (Note: Moving the lower jaw moves the tongue off the throat and opens the airway.) c. Perform the finger sweep using your index finger as a hook. (1) Insert your index finger into the resident's mouth alongside of the cheek and across the base of the tongue. (2)Try to remove any foreign objects. (3) Avoid pushing foreign objects deeper into the throat. (4) Turn the resident's head to one side if needed to sweep an object from the mouth. 6. Alternate steps four 4) and five (5) until the object is expelled. Arrange for the resident to be evaluated by a physician immediately after the foreign body airway obstruction has been removed. 7. If unable to clear the foreign body from obstructing the airway,	IDENTIFICATION NUMBER: 395721  STREET ADDRESS, CITY, STATE, ZIP CODE: 6375 CHAMBERSBURG ROAD FAYETTEVILLE, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued from page 6  Chest. c. Place the other hand directly over the positioned hand. d. Bring your shoulders forward over your hands. e. Use your body weight to press your hands into the resident's upper abdomen with a quick upward thrust. 5. Perform finger sweep maneuver to check for a foreign body as follows: a. Keep the resident's face up. b. Perform the tongue-jaw lift to open the resident's mouth. (Note: Moving the lower jaw moves the tongue off the throat and opens the airway.) c. Perform the finger sweep using your index finger as a hook. (1) Insert your index finger into the resident's mouth alongside of the check and across the base of the tongue. (2)Try to remove any foreign objects. (3) Avoid pushing foreign objects deeper into the throat. (4)  Turn the resident's head to one side if needed to sweep an object from the mouth. 6. Alternate steps four 4) and five (5) until the object is expelled.  Arrange for the resident to be evaluated by a physician immediately after the foreign body airway obstruction has been removed. 7. If unable to clear the foreign body from obstructing the airway,	A BLDG: 00 B WING: 10/06/2025    A BUDG: 00 B WING: 10/06/2025   A STAILET ADDRIVES. CITY, STATE, 2IP CODE: 6375 CHAMBERSBURG ROAD FAVETTEVILLE, PA 17222   A BUDG: 00 B WING: 10/06/2025   A VING:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION:  A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395721		B. WING: _		10/06/2025		
PARAMO AT FAYE	VIDER OR SUPPLIER: UNT NURSING AND REH ITEVILLE, LLC SE NUMBER: 420102	ABILITATION	STREET ADDRESS, 6375 CHAMB FAYETTEVII	ERSBURG	ROAD			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE	
F 0684	Continued from page 7			F 0684				
SS=J	nearest acute care med CPR immediately if the respirations."  Review of Resident 1's he was admitted to the 2025, with diagnoses of a trauma or a weakening second lumbar (lower paltered mental status, at the following orders: Review of Resident 1's the following orders: Review, with thin consigerichair with left arm and incline during mean DNR/Do Not Attempt Therapy (ST) Eval &, Thera	s clinical record reversacility on September hat included a composer vertebra possibly during of the vertebra) of the part of the back) vertebrand muscle weakness aphysician orders reactly and muscle weakness aphysician orders reactly. Out of bed to support (Recline challs), Advanced Directly, Adv	aled that er 10, ression e to he tebra, s. vealed ical Soft o air at rest tive ch x 30 lty Therapy ites of					

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			IPLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	EY
		395721		A. BLDG: _ B. WING: _	10/06/2025		
PARAMOU AT FAYET	VIDER OR SUPPLIER: UNT NURSING AND REH TTEVILLE, LLC E NUMBER: 420102	ABILITATION	STREET ADDRESS, 6375 CHAMB FAYETTEVII	ERSBURG	ROAD		
(X4) ID PREFIX TAG	PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0684	Continued from page 8	ued from page 8					
SS=J	2025.  Review of Speech Therapy Evaluation and Plan of Treatment dated September 10, 2025, completed by Employee 3 (Speech Language Pathologist) noted that Resident 1 was referred to ST due to						
	exacerbation of cognitive safety awareness, decreased	eased oral pharynge	al				
	function, risk for weight decreased functional ac- resident in compensate aspiration risk and pro-	ctivity. ST was to incory strategies and mi	struct the nimize				
	Review of Resident 1's report note dated Septe by Employee 3, stated, Swallow Tx [treatment facilitation of small bit tspteaspoon), facilitation intake of food/liquid prof bolus sizes and order presentation. Pt and Capatient and primary can	ember 20, 2025, com "Interventions proval]: facilitation of fing es/sips (1/2 to 1/3 on of rate control duresentation and moder/method of food/licategiver Training: In	ring oral ification quid structed				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)  (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBER  395721			A. BLDG: _	IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 10/06/2025		
PARAMOU AT FAYET	VIDER OR SUPPLIER: UNT NURSING AND REH. TTEVILLE, LLC	ABILITATION	STREET ADDRESS. 6375 CHAMB FAYETTEVII	ERSBURG	ROAD		
STATE LICENS	E NUMBER: <b>420102</b>						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICI MUST BE PRECEEDED BY FULL REGULATORY OR LS IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
F 0684	Continued from page 9			F 0684			
SS=J							
	techniques in order to	facilitate improved f	unctional				
	abilities with 100% car	d by					
	primary caregivers."						
	Review of Resident 1's Occupational Therapy						
	Evaluation and Plan of	Treatment dated Se	ptember				
	10, 2025, completed by	y Employee 11					
	(Occupational Therapi	st), stated, "Res[ider	nt] noted				
	with decreased safety a	awareness."					
	Review of Resident 1's	S Occupational Thera	ару				
	Progress Report note d	lated September 20,	2025,				
	completed by Employe	ee 11, indicated Resi	dent 1				
	was provided education	n and encouragemen	nt to				
	initiate self-feeding and	d increase intake. In	addition,				
	in supervision section,	it was noted "Comp	leted				
	on-site consultation be	tween therapist and	assistant				
	regarding patient's curr	rent status and modif	fied POT				
	[plan of treatment]/goa	als." It was electronic	cally				
	signed by Employee 1	(Certified Occupation	onal				
	Therapy Assistant) and	l Employee 11.					
	Review of Resident 1's	s progress notes reve	ealed a				

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/G IDENTIFICATION NUMBER			IPLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	EΥ
		395721		A. BLDG:00 B. WING:			
PARAMOI AT FAYET	VIDER OR SUPPLIER: UNT NURSING AND REH TTEVILLE, LLC SE NUMBER: 420102	ABILITATION	STREET ADDRESS. 6375 CHAMB FAYETTEVII	ERSBURG	ROAD		
(X4) ID	SUMMARY STATEMENT	OF DEFICIENCIES (EACH DE		ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX TAG	MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		R LSC	PREFIX TAG	CORRECTIVE ACTION SH CROSS-REFERENCED TO THE .		COMPLETE DATE
F 0684	Continued from page 10			F 0684			
SS=J							
	note dated October 1, 2	2025, at 11:30 AM,					
	completed by Employe	ee 13 (Registered Nu	arse), that				
	stated, "At approximate	ely 1130, resident o	bserved				
	choking during meal co	-	_				
		resident to cough and brought resident to his room.					
	Staff immediately initiately						
	oral suctioning. Staff e	-	_				
	but resident was unable	• .	•				
	to medical conditions.						
	airway obstruction, wit						
	to speak effectively. Of						
	placed on resident duri	•					
	attempts. Emergency p		d 911				
	called. At 1157, residen						
	consciousness with no						
	movement. Auscultation						
	audible heart sounds or						
	with no palpable caroti	•					
	B/L [bilaterally-both si	-	•				
	and warm to touch. Pu	•					
	[Medical Doctor] upda	ned with new order	IOT KIN				
	to pronounce death."						
				1			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:  A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395721		B. WING:		10/06/2025	
PARAMOI	VIDER OR SUPPLIER: UNT NURSING AND REH TTEVILLE, LLC	ABILITATION	STREET ADDRESS, 6375 CHAMB FAYETTEVII	ERSBURG	ROAD		
STATE LICENS	E NUMBER: <b>420102</b>			-	<b>.</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH D MUST BE PRECEEDED BY FULL REGULATORY ( IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0684	Continued from page 11			F 0684			
SS=J	Further review of Resirevealed a late entry no 12:57 PM, completed to (RN-Assistant Director) "This nurse was informincident around 11:40 DON [Director of Nursing] or nurse's station, checked noted resident was DN points."	ote dated October 1, by Employee 6 or of Nursing), that staned of a possible choosing]/ADON [Assist ffice. This nurse stop d resident's POLST and the stop of the	2025, at ated bking owards cant oped at				
	noted resident was DN Supervisor (Employee phone w/[with] 911 op This nurse then entered [Licensed Practical Nu suction at bedside. 2 C Aides] (Employees 4 at therapy staff [Employees Therapy Assistant) and made staff aware that hinterventions and that the efforts and suctioning,	13) was at desk on the reator reporting incideresident's room to the resident's room to the resident of the resident of the room to the resident of the room to the resident of the room to the	dent. find LPN ttempting se well as 2 pational nurse nited Heimlich rebreather				
	mask to help with any Resident complexion a						

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		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION:  A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395721				10/06/2025		
PARAMO AT FAYET	IVIDER OR SUPPLIER: UNT NURSING AND REH. ITEVILLE, LLC SE NUMBER: 420102	ABILITATION	STREET ADDRESS, 6375 CHAMB FAYETTEVII	ERSBURG	ROAD			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY PREFIX MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0684 SS=J	eyes did follow staff in exchange with notable Heimlich. Staff unable resident's mouth, and s small amounts of mucc and air exchange had c obtain O2 saturation, a to deteriorate. Resident appeared pale while be At this time staff direct attempted to feel radial then attempted to ausci seconds with no pulse non-responsive. RN su notified MD, MD givin resident's death at 11:5  Review of witness state (Certified Occupational part, "At approximately resident half of a soft be 2.5 inches in size. Resident his mouth of the control	wheezing while atterto visualize the blocuctioning only productioning only productions with tiny crumbs reased completely. Under residents color control to the consciousness of	empting ckage in ucing s of debris, Unable to continued and face yanotic. nis nurse of there, or >60  13) ce  inployee 1 in read, in ed ed eximately half of	F 0684				

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STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER. PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER			(X2) MULTI	PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	ΞY			
	( 00)			A. BLDG: _					
		395721		B. WING: _		10/06/2025			
PARAMOI	VIDER OR SUPPLIER: UNT NURSING AND REH. TTEVILLE, LLC	ABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE: 6375 CHAMBERSBURG ROAD FAYETTEVILLE, PA 17222						
	420102								
STATE LICENS (X4) ID	E NUMBER: 420102	OF DEFICIENCIES (EACH DE	EICIENCY	ID	ND OVER DE DE CARDO	CTION (F. LOW	(V5)		
PREFIX TAG	MUST BE PRECEEDI IDENTI		PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE			
F 0684	Continued from page 13			F 0684					
SS=J	1.1								
	verbal cues to instruct								
	numerous times. Resid	•							
	remaining enchilada he								
	noticed resident having		C						
	exhibit labored breathi	-	-						
	instructed resident to k								
	stated, 'I can't'. I then in	•	Employee						
	2 and 3 for further assi	stance."							
	Review of witness state	-							
	(Licensed Practical Nu								
	called to the dining roo	om for resident chok	ing. I						
	noted he was awake an	nd breathing with lor	ng						
	wheezing respirations.	No cyanosis noted a	at that						
	time. I raised back of v	wheelchair to a full n	inety						
	degree angle with resid	dent continuing to ha	ive air						
	exchange. Coughed at	one time and a mode	erate						
	amount of mucous was	s expectorated. Staff	present						
	encouraged him to cou	gh to which he repli	ed in a						
	whisper 'I can't'.' We to	ook resident to his ro	oom,						
	assisted him to his bed	and placed lying on	left side.						
	Respirations at this tim	ne were deeper with	good						
	exchange. I attempted	-	_						
	_	•							
						,	, ,		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:  A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395721		B. WING: _		10/06/2025	
PARAMO AT FAYET	VIDER OR SUPPLIER: UNT NURSING AND REH. ITEVILLE, LLC SE NUMBER: 420102	ABILITATION	STREET ADDRESS, 6375 CHAMB FAYETTEVII	ERSBURG	ROAD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0684	Continued from page 14			F 0684			
SS=J	small amount of food I Unable to visualize any of mouth. Continued to resident became unresp attempted abdominal th results."  Review of witness state read, in part, "I entered followed [Employee 2 to resident's room. I wa and clear throat. I put a if he could be visually observed staff place re- suctioned resident and cough."  Review of witness state (Nurse Aide) read, in p resident down hall and ran and grabbed the lif [Employee 2 and other Therapist [Employee 3	ement written by End the dining room and (Licensed Practical as saying to resident an apkin in front of he cued to spit it out or sident in bed. [Empl I continued to tell his part, "I saw staff compart, "I saw staff compart, "I saw staff compart, "There were two nursunidentified), a Spetal special succession.	nspection ning when e. Staff without  nployee 3 d Nurse)] cough nim to see cough. I oyee 2] im to  nployee 4 ning with choking. I nrses				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:  A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395721				10/06/2025	
NAME OF PROVIDER OR SUPPLIER: PARAMOUNT NURSING AND REHABILITATION AT FAYETTEVILLE, LLC STATE LICENSE NUMBER: 420102			STREET ADDRESS, 6375 CHAMB FAYETTEVII	ERSBURG	ROAD		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY CONTROL TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0684	Continued from page 15			F 0684			
SS=J	Pathologist)], and a the in the room. [Employe him in bed with the lift hard and he mouthed 'I (Licensed Practical Nu nothing came out. I put did the sweep to see if I couldn't feel anything Nurse-Assistant Direct the room and told us he immediately started the around 11:50 AM. I could then [Employee 5 took on performing the Heir [Employee 6] told us to [Employee 6] to checke there. Determined residuation."  Review of witness stated, in part, "I assisted As we lowered him into cough repeatedly over	e 5 (Nurse Aide)] and a like the telling him to a can't'. [Employee 2 arse)] tried to suction at my finger [in his mand of the telling him to a could remove any general the telling him to a could remove and the telling him	and I got o cough him but houth] and food, but istered came in er. It was red and I off and I pulse. wasn't 12  hiployee 5 the lift. him to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
	395721			A. BLDG:00_ B. WING:		10/06/2025	
NAME OF PROVIDER OR SUPPLIER: PARAMOUNT NURSING AND REHABILITATION AT FAYETTEVILLE, LLC STATE LICENSE NUMBER: 420102			STREET ADDRESS, 6375 CHAMB FAYETTEVII	ERSBURG	ROAD		
				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0684	Continued from page 16			F 0684			
SS=J	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		395721			00	10/06/2025	
NAME OF PROVIDER OR SUPPLIER: PARAMOUNT NURSING AND REHABILITATION AT FAYETTEVILLE, LLC STATE LICENSE NUMBER: 420102			STREET ADDRESS, 6375 CHAMB FAYETTEVII	ERSBURG	ROAD		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DIPREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0684	Continued from page 17			F 0684			
SS=J	During a staff interview (RN-Assistant Director 2025, at 1:03 PM, it was 1's choking incident staff did not initiated Maneuver until approximately 10 minus. During a staff interview October 3, 2025, at 1:2 when she entered the diseated in his high back a 7580-degree angle. Himmediately raised Redegree angle. When Er Resident was taken back transferred to bed beforwere initiated for the complete the disease of the still had some air of get him out of the dining residents." Employee 2	r of Nursing) on Oct as confirmed that Rearted around 11:40 Aste the actual Heimlic timately 11:50 AM, attes.  W with Employee 2 of 20 PM, Employee 2 said she awheelchair at approximately 1's chair to a finployee 2 was asked to his room and re any emergency makes the confirmation of th	esident AM and th a delay of on said at 1 was oximately full 90 d why the teasures stated, anted to the other	F 0004			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:			
	, ,	205721		A. BLDG: _ B. WING:	00	10/06/2025			
		395721				10/00/2020			
	VIDER OR SUPPLIER: J <b>NT NURSING AND REH</b> A	ARILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE: 6375 CHAMBERSBURG ROAD						
	TEVILLE, LLC	TELEVITORY	FAYETTEVII						
CTATE LICENIC	e number: <b>420102</b>								
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH D		OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORRE	CTION (EACH	(X5)		
PREFIX				PREFIX TAG	CORRECTIVE ACTION SH	OULD BE	COMPLETE DATE		
170		TING INFORMATION)			CROSS-REFERENCED TO THE A	APPROPRIATE	DATE		
F 0684	Continued from page 18			F 0684					
SS=J									
55 3	to the dining room for	all meals and was or	n the						
	assisted side of the din								
	confirmed that Residen	nt 1 had poor safety							
	awareness because of h	nis cognitive impairr	nent.						
	Employee 2 also said the	hat the typical proce	ss for						
	someone on a mechani	cal soft diet was to h	nave their						
	food cut up into bite siz	ze pieces and that sh	e could						
	not speak as to why En								
	the day Resident 1's ch	oking incident occur	rred.						
	Resident 1's room was	located at the end of	f the						
	hallway. During a staff								
	with Employee 9 (Main								
	October 3, 2025, at 3:0	· · · · · · · · · · · · · · · · · · ·							
	the distance from the d		ent 1's						
	room was approximate	ely 138 feet.							
	On October 3, 2025, at	3:12 PM, the Nursi	ng						
	Home Administrator (N	NHA) was informed	that an						
	Immediate Jeopardy si	tuation had been ide	ntified						
	and the IJ template was	s provided. An imme	ediate						
	action plan was reques	ted.							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395721		A. BLDG: _ B. WING: _	00.	10/06/2025	
PARAMOUNT NURSING AND REHABILITATION 637.			STREET ADDRESS, 6375 CHAMB FAYETTEVII	ERSBURG	ROAD		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEF PREFIX MUST BE PRECEEDED BY FULL REGULATORY OR IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0684	Continued from page 19			F 0684			
SS=J	The NHA provided the Plan on October 3, 2022  The plan of action incl Choking policy was re American Heart Assoc staff currently working educated by the Assistathe revised choking pobe educated by the Resprior to the start of their full-time, part-time, an staff. The Assistant Dirall nursing staff curren look for when someone all full-time, part-time, staff. The  Rehab Manager audite caseload immediately to Therapy diet recommendately to the Rehab Manager audite caseload immediately to the Rehab Manager audite caseload im	uded: viewed and updated iation Standards. Al in the building will ant Director of Nurs. licy. All other nursing gistered Nurse Super ir shift. This will ince d prn [as needed] nur rector of Nursing wi tly working on the se is choking. This wa and prn [as needed] d all residents on cur to ensure current Spendations were being Manager will audit al	to I nursing be ing on ng staff will visor lude all ursing Il educate igns to ill include   nursing  rrent eech				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:  A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395721		B. WING: _		10/06/2025	
PARAMO AT FAYET	VIDER OR SUPPLIER: UNT NURSING AND REH ITEVILLE, LLC SE NUMBER: 420102	ABILITATION	STREET ADDRESS, 6375 CHAMB FAYETTEVII	ERSBURG	ROAD		
(X4) ID PREFIX TAG	PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0684	Continued from page 20		F 0684				
SS=J	recommendations toen reflects Speech Therap On October 4, 2025, m between 7:45 and 8:52  Interviews, review of reducation, and review October 4, 2025, between AM, revealed the facilimmediate actions as swere conducted with 2 Licensed Practical Nurwere all able to state simmediate actions to to occur. They were all all Speech Language Path would be communicated also conducted with a who was able to state the ensure that recommend the dietary department. Occupational Therapy	real service observate AM, revealed no conversed policy, review of audits conducted een 8:35 AM and 11 ity had completed altated in their plan. In Registered Nurses, reses, and 4 Nurse Aid gns of choking and the should a choking also able to indicate hologist diet recommend to them. Interview Speech Language Pathe process to be foll dations are communicated and with a Certificated	ions oncerns.  w of on :25 1 nterviews 2 des who the g incident ow endations vs were athologist owed to icated to d				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT	IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
	, ,	395721		A. BLDG: _ B. WING: _	00	10/06/2025	
		373721		1			
	VIDER OR SUPPLIER: U <b>NT NURSING AND REH</b> .	ABILITATION	STREET ADDRESS, 6375 CHAMB				
	TEVILLE, LLC		FAYETTEVII	LLE, PA 17	7222		
STATE LICENS	E NUMBER: <b>420102</b>						
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH D PREFIX MUST BE PRECEEDED BY FULL REGULATORY (				ID	PROVIDER'S PLAN OF CORRE	,	(X5)
PREFIX TAG	MUST BE PRECEEDE IDENTII	R LSC	PREFIX TAG	CORRECTIVE ACTION SH CROSS-REFERENCED TO THE		COMPLETE DATE	
F 0684	Continued from page 21			F 0684			
gg I							
SS=J	a Speech Therapist's diet recommendations would		s would				
	be located on a residen		Would				
	Interviews with two Di	•	d that they				
	were both able to state	the measures they a	re to				
	take in preparing a resi	dent's meal tray for	delivery.				
	An interview with the						
	process he had develop	•					
	dietary staff to ensure a						
	appropriate diet and the						
	Pathologist recommend	dations are followed	•				
	On October 4, 2025, at	: 11:35 AM, the Imn	nediate				
	Jeopardy was lifted.	,					
	Davis and Constant Coint		<b>.</b>				
	During a final staff into October 6, 2025, at 1:5						
	she would have expect	· · · · · · · · · · · · · · · · · · ·					
	emergency measures for	•					
	immediately instead of		•				
	back to his room, trans	•					
	waiting for further dire						
	Maneuver.						

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTI A. BLDG: _ B. WING: _	IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 10/06/2025	
PARAMOU	VIDER OR SUPPLIER: UNT NURSING AND REH. TEVILLE, LLC	ABILITATION	STREET ADDRESS, 6375 CHAMBI FAYETTEVII	ERSBURG	ROAD		
STATE LICENS	E NUMBER: <b>420102</b>						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DI MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)			ID PREFIX TAG			(X5) COMPLETE DATE
F 0684	Continued from page 22			F 0684			
SS=J	The facility failed to proservices, including the Resident 1 when he was resulted in an immedia 28 Pa. Code 201.14(a) 28 Pa. Code 201.18(b) 28 Pa. Code 211.10(d) 28 Pa. Code 211.12(d) services.	Heimlich maneuver as choking. This failute jeopardy situation Responsibility of lice (1) Management.  Resident care polici	e, to ure n. censee.				
F 0689				F 0689			
SS=J							

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		(XI) PROVIDER/SUPPLIER/CIDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION:  A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 10/06/2025	
NAME OF PROVIDER OR SUPPLIER: PARAMOUNT NURSING AND REHABILITATION AT FAYETTEVILLE, LLC			STREET ADDRESS, 6375 CHAMB FAYETTEVII	ERSBURG	ROAD		
STATE LICENS	STATE LICENSE NUMBER: 420102						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICI MUST BE PRECEEDED BY FULL REGULATORY OR LS IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
F 0689	Continued from page 23			F 0689			
SS=J	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices				We were unable to correct		Completion Date:
	§483.25(d) Accidents.  The facility must ensure that - §483.25(d)(1) The resident environment remains as free				deficiency F0689 related to I 1 as resident expired in the fa Residents 6-14 were screene Speech Therapy for appropri	10/31/2025 Status: APPROVED Date:	
	accident hazards as is possible		nec or		and checked to see if at risk choking or require any new s	for	10/20/2025
	§483.25(d)(2)Each resident and assistance devices to pr		supervision		measures. Director of Rehab all current residents that have speech therapy diet recomme	e had a	
	This REQUIREMENT is not met as evidenced by:				to ensure their current diet of reflects speech therapy recommendations. Director educated all therapy staff on procedure of diet recommend	of Rehab the new	
					to be written on the speech the recommendation form and provider as well as provided to a Speech Therapy was also educated to the speech Therapy was also educated to	hysician nursing.	
					to give the speech therapy recommendation form to Die Speech Therapist were instru trialing any changes to the di therapist must stay with resid	etary. acted if iet	
					until trial item is completed.		

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of Rehab is conducting an ongoing audit for any new speech therapy recommendations to ensure they match the diet order. All nursing

	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		` ´	PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	EY
		395721				10/06/2025	
PARAMO AT FAYET	VIDER OR SUPPLIER: UNT NURSING AND REH. FTEVILLE, LLC SE NUMBER: 420102	ABILITATION	STREET ADDRESS, 6375 CHAMB FAYETTEVII	ERSBURG	ROAD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0689 SS=J	Continued from page 24			F 0689	staff was educated prior to the of their shift on the new cholopolicy and signs and symptolook for with a choking reside Education was given to all notation to the start of their on diet and diet textures. Die Manager educated all dietary prior to the start of their shift and diet textures and cutting as indicated on the meal tick Dysphagia/Choking Procedurin-service was provided to the by Anthony Clark, Director Nursing and Talayne Gates, Tuesday, October 14th at 7ar and 3pm and will be provided Thursday, October 16th at 7ar and 3pm to licensed staff and nursing assistants. Director Nursing and Assistant Dietar Manager is conducting audit new dietary orders or change recommendations for meal tick accuracy through October 31. The Dietary Manager auditemeals during tray line service ensure meal ticket matches dand visually observe meal service and visually observe meal service.	king ms to dent. ursing r shift etary y staff t on diet up food et. ure ne staff of SLP on m, 1pm ed on am, 1pm d of ry s of all es and icket 1, 2025. d all ee to liet order	

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	EY
		395721		1	<u>uu</u>	10/06/2025	
PARAMOI AT FAYET	VIDER OR SUPPLIER: UNT NURSING AND REH. ITEVILLE, LLC JE NUMBER: 420102	ABILITATION	STREET ADDRESS, 6375 CHAMB FAYETTEVII	ERSBURG	ROAD		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEI PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0689	Continued from page 25			F 0689			
SS=J					accurate through 10/10/25. Beginning 10/13/25, Dietary Manager will audit 3 meals puring tray line to ensure mematches diet order and visual observe meal served is accurathrough October 31, 2025. Inservice training on F0689 Accidents and incidents for a licensed staff and nursing asswill be provided by Sophie CMSN, RN, CRRN, RAC-CTCNDLTC. Sophie Campbel Executive Director of the Pennsylvania Association of Directors of Nursing Administration and is an approved directed inservice provider on the list the Department of Health. The directed staff inservice will on Wednesday, October 29th 1pm and 3pm. This inservice recorded for staff that is unal attend. Licensed staff unable attend the inservice will be to watch the recorded inservice at the monthly QAPI to deter further auditing is needed.	per week per week per television of the beheld of at 7am, ce will be belet to be to required vice of shift.	

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULT	PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	ΞY
		20.5524		A. BLDG: _ B. WING:		10/06/2025	
		395721				10/00/2023	
	VIDER OR SUPPLIER: UNT NURSING AND REH.	ARII ITATION	STREET ADDRESS, 6375 CHAMB				
	TTEVILLE, LLC	ADILITATION	FAYETTEVII				
OT LED LIGHT	95 May 1955 120102						
(X4) ID	SE NUMBER: <b>420102</b> SUMMARY STATEMENT	OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORREC	CTION (EACH	(X5)
PREFIX TAG		ED BY FULL REGULATORY OF	R LSC	PREFIX TAG	CORRECTIVE ACTION SH	OULD BE	COMPLETE
TAG	IDENTI	FYING INFORMATION)			CROSS-REFERENCED TO THE A	APPROPRIATE	DATE
F 0689	Continued from page 26			F 0689			
gg I							
SS=J			•••				
	Based on clinical recor		•				
	document review, review	•	-				
	of select resident meal	-					
	interviews, it was deter to ensure that each resi		-				
	supervision and assista	•					
	based on individual ne	•					
	1), which resulted in R		`				
	placed nine residents th	•					
	high risk for death and						
	Jeopardy situation (Res						
	13 and 14).	, , , , , , , , , , , , , , , , , , ,	11, 12,				
	Findings include:						
	Review of facility docu	ument, titled "Mecha	nically				
	Altered Diets", last rev	riewed January 23, 2	025,				
	read, in part, "Dysphag	gia Diet Level 2: Lev	el 2 can				
	tolerate (most of the tir	me) this texture as it	should be				
	the easiest to maneuver	r and safe to swallov	v.				
	Mechanically altered for	ood should be very s	small in				
	size, soft, and with extr	ra moisture added."					

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		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:  A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395721		1		10/06/2025	
PARAMO AT FAYE	VIDER OR SUPPLIER: UNT NURSING AND REH TTEVILLE, LLC SE NUMBER: 420102	ABILITATION	STREET ADDRESS, 6375 CHAMB FAYETTEVII	ERSBURG	ROAD	,	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DI PREFIX MUST BE PRECEEDED BY FULL REGULATORY ( TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
F 0689 SS=J	Review of Resident 1's diagnoses that included malnutrition (an imball body needs to function dehydration (the loss of normal body function) weakness.  Review of Resident 1's he had an order for "Retexture, Thin consistent September 10, 2025.  Review of select facility residents who were ordexture were to be serventrée for lunch on Octation (Comment titled "Speed Plan of Treatment" sig September 10, 2025, reterier le l'attent referrement (Comment titled Tentre l'attent referrement).	d unspecified protein ance between the number of and the nutrients it of water and salts esse, and generalized must be physician's orders regular diet, Mechanically, with a start date ty diet guidelines revolved a beef enchilada tober 1, 2025.  Is clinical record reveals to the control of t	n-calorie trients the gets), ential for uscle revealed ical Soft e of  vealed ft diet as their  raled a on &; on i for	F 0689			

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	FEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER (XI) PROVIDER/SUPPLIER (DENTIFICATION NUMBER (XI) PROVIDER/SUPPLIER (XI) PROVIDER (XI) PROVI			(X2) MULTIPLE CONSTRUCTION:  A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395721		B. WING: 10/06/2025			
PARAMOI AT FAYET	VIDER OR SUPPLIER: UNT NURSING AND REH TEVILLE, LLC E NUMBER: 420102	ABILITATION	STREET ADDRESS. 6375 CHAMB FAYETTEVII	ERSBURG	ROAD		
(X4) ID PREFIX	SUMMARY STATEMENT	OF DEFICIENCIES (EACH DE		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE A CETON SH		(X5) COMPLETE
TAG		FYING INFORMATION)	K LSC	TREFIX TAG	CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A		DATE
F 0689	Continued from page 28			F 0689			
SS=J							
	due to exacerbation of	cognitive impairme	nt,				
	decreased safety aware						
	oral/pharyngeal function						
	aspiration (when some	C					
	airway or lungs), and d		activity				
	tolerance indicating the						
	assess/evaluate least re	estrictive oral intake	develop				
	compensatory strategie	-					
	awareness/insight and	increase verbal prob	lem				
	solving."						
	Review of Resident 1's	Speech Therapy pr	ogress				
	report note dated Septe	ember 20, 2025, con	pleted				
	by Employee 3 (Speech	h Language Patholo	gist)				
	indicated "Intervention	s provided: Swallov	v Tx				
	[treatment]: facilitation	n of finger foods, fac	cilitation of				
	small bites/sips (1/2 to	1/3 tsp), facilitation	of rate				
	control during oral inta	ake of food/liquid pr	esentation				
	and modification of bo	lus sizes and order/i	nethod of				
	food/liquid presentation	n. Pt and Caregiver	Training:				
	Instructed patient and p	primary caregivers i	n safe				
	swallow techniques in						
	functional abilities with	h 100% carryover					

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PLAN OF CORRECTION (POC)  (X1) PROVIDERSUPPLIER.  (X2) PROVIDERSUPPLIER.  (X3) PROVIDERSUPPLIER.			A. BLDG: _	00	COMPLETED:	ΕΥ	
		395721		B. WING: _		10/06/2025	
PARAMOU AT FAYET	NAME OF PROVIDER OR SUPPLIER: PARAMOUNT NURSING AND REHABILITATION AT FAYETTEVILLE, LLC STATE LICENSE NUMBER: 420102			CITY, STATE, Z ERSBURG LLE, PA 17	ROAD		
(X4) ID PREFIX TAG	X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH D REFIX MUST BE PRECEEDED BY FULL REGULATORY (			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0689	Continued from page 29			F 0689			
SS=J	demonstrated by prima	ary caregivers."					
	Review of document, t	itled "Speech Thera	ру				
	Discharge Summary",						
	Employee 3 on Octobe		-				
	"Comments: Mechanic	Č	*				
	food cut into bite size p bites/sips (1/2 to 1/3 tsp		oi smaii				
	Review of Resident 1's	meal tray ticket fro	m				
	October 1, 2025, failed	l to reveal notation to	hat his				
	food should be cut into	bite size pieces.					
	Review of facility prov	vided information da	ted				
	October 1, 2025, revea						
	Resident 1 a half of an		C				
	approximately 2.5 inch	· ·					
	Resident took one bite						
	small bites, he proceed enchilada in his mouth	•					
	Resident having a blan						
	exhibiting labored brea		•				
	2.2.2.2						

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	PLAN OF CORRECTION (POC)  (A1) PROVIDERSUPPLIES IDENTIFICATION NUMBER  395721			A. BLDG:00  B. WING:		(A3) DATE SURVEY COMPLETED:  10/06/2025	
		395/21				10/00/2023	
PARAMOU AT FAYET	VIDER OR SUPPLIER: UNT NURSING AND REH. TEVILLE, LLC E NUMBER: 420102	ABILITATION	6375 CHAME FAYETTEVI	BERSBURG I	ROAD		
(X4) ID		OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORRE	CTION (EACH	(X5)
PREFIX TAG	MUST BE PRECEEDE	ED BY FULL REGULATORY O FYING INFORMATION)		PREFIX TAG	CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	COMPLETE DATE
F 0689	Continued from page 30			F 0689			
SS=J							
	Review of the witness	-					
	Employee 1 (Occupation	1 /					
	on October 1, 2025, "A		•				
	I handed resident half of						
	approximately 2.5 inch pushed half of the ench						
	visual and verbal cues		•				
	down numerous times.						
	the remaining enchilad		-				
	mouth. I noticed reside	_					
	starting to exhibit labor	-					
	speak. I instructed resid	•					
	Resident stated, 'I can't						
	Employee 2 (Licensed	•					
	Employee 3 (Speech L	anguage Pathologist	t) for				
	further assistance."						
	Review of witness state	-					
	read, in part, "I was cal	•					
	resident 'choking.' I no						
	breathing with long wh						
	cyanosis (skin, lips or i						
	oxygen in your blood)	noted at that time. I	raised the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)  (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:		
		395721		A. BLDG: _ B. WING: _		10/06/2025	
PARAMO AT FAYET	VIDER OR SUPPLIER: UNT NURSING AND REH TTEVILLE, LLC SE NUMBER: 420102	ABILITATION	STREET ADDRESS, 6375 CHAMB FAYETTEVII	ERSBURG	ROAD		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DI PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0689	Continued from page 31			F 0689			
SS=J	back of the wheelchair resident continuing to at one time and modera expectorated. Staff precontinue to cough to we can't."  During an interview we Director) on October 3 revealed Employee 1 we to trial finger foods and could not answer as to larger than his recommensize pieces.  Interview with Employee 11:10 AM, she indicate the assisted side of the could assist him with easistance would incluver bally cueing him to him time to take rest be with feeding if unable with cueing. She said to	have air exchange. Cate amount of mucousent encouraged him hich he replied in a hith Employee 7 (The 2025, at 2:56 PM, was working with Red self-feeding tasks, why she provided for ended diet consister wee 3 on October 4, 2 and that the Resident dining room so that eating. She indicated de staff cutting up for feed himself small breaks as needed, and to complete independ	coughed us was in to whisper 'I erapy she esident 1 but she cood intly of bite erapy at the erapy staff that cood, bites, allow assist idently or				

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	MENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIED F CORRECTION (POC) IDENTIFICATION NUMBER				IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
	395721			A. BLDG:00_ B. WING:		10/06/2025	
PARAMOI AT FAYET	VIDER OR SUPPLIER: UNT NURSING AND REH. TTEVILLE, LLC	ABILITATION	STREET ADDRESS, 6375 CHAMB FAYETTEVII	ERSBURG	ROAD		
(X4) ID	E NUMBER: <b>420102</b> SUMMARY STATEMENT	OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORRE	CTION (EACH	(X5)
PREFIX TAG	MUST BE PRECEEDE	ED BY FULL REGULATORY OF		PREFIX TAG	CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	COMPLETE DATE
F 0689	Continued from page 32			F 0689			
SS=J	recommendations for a put on the resident's tra should always be cuttin size pieces on the assis She said she had not sp. Employee 1 regarding precautions. She said the Language Pathologist of know for sure what was speculation, Employee Resident a fourth of the some of the cheese off.  Review of Resident 6 and October 1, 2025, reveal meats."	ay ticket, but said that ang up a resident's footsted side of the dining pecifically spoken to Resident 1's diet or that the other Speech may have, but she was discussed. She said at 1 should have given the enchilada at a time of the enchilada.	at staff od to bite g room.  rould not d in her n the e or push				
	Review of Resident 8, tickets from October 1 "cut up food."		-				
	Review of Resident 10 October 1, 2025, revea	-					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)  (XI) PROVIDER/SUPPLIER. IDENTIFICATION NUMBE			A. BLDG: _		(X3) DATE SURVEY COMPLETED:		
		395721		B. WING:		10/06/2025	
PARAMOU AT FAYET	VIDER OR SUPPLIER: UNT NURSING AND REH. TEVILLE, LLC E NUMBER: 420102	ABILITATION	6375 CHAMB FAYETTEVII	BERSBURG	ROAD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0689 SS=J	Continued from page 33  into bite size pieces."  Review of Resident 13 from October 1, 2025, food into small pieces.  Interview with the Nur (NHA) on October 6, 2 she would expect speed to be communicated pr tray tickets; and she we recommendations to be  The NHA was notified October 3, 2025, at 3:1 incident that occurred of provided the IJ templat was requested. The Immediate Action NHA on October 3, 20 PM.  The approved plan incl	revealed direction for " ssing Home Administ 2025, at 2:09 PM, rech therapy recommer roperly and noted on ould expect speech to effollowed.  of the IJ situation of 2 PM, for the choking October 1, 2015 at the E. An Immediate Administration of the IJ saturation of 2 PM, for the choking on October 1, 2015 at the E. An Immediate Administration of the IJ saturation of 2 PM, for the choking on October 1, 2015 at the E. An Immediate Administration of the IJ saturation of t	or "cut strator vealed endations meal herapy  n ng and was ection Plan	F 0689			
	The approved plan me	iddod.					

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STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/OF PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:		
395721				A. BLDG:00_ B. WING:		10/06/2025	
PARAMOU AT FAYET	VIDER OR SUPPLIER: UNT NURSING AND REHL TEVILLE, LLC	ABILITATION	STREET ADDRESS, 6375 CHAMB FAYETTEVII	ERSBURG	ROAD		
	E NUMBER: 420102	OF DEFICIENCIES (FACIL DE	EIGIENGV	ID		amro. 1 / D + 011	(V.5)
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE	
F 0689	Continued from page 34			F 0689			
SS=J							
	· Choking policy was r	eviewed an undated	to				
	American Heart Assoc	•					
	· All nursing staff curre		building				
	will be educated by En		•				
	on the revised choking	policy.	,				
	· All other nursing staf	f will be educated by	y the				
	Registered Nurse (RN)	Supervisor prior to	the start				
	of their shift. This will	include all full time	, part-time				
	and nursing staff.						
	· Employee 6 will educ	ate all nursing staff	currently				
	working on the signs to	look for when som	eone is				
	choking.						
	· All other nursing staff	f will be educated by	y the RN				
	Supervisor prior to the	start of their shift. T	This will				
	include all full time, pa	art-time and nursing	staff.				
	· Employee 7 audited a	ll residents on curre	nt				
	caseload immediately t	to ensure current spe	eech				
	therapy diet recommen	dations were being	followed.				
	· Employee 7 will audi	t all residents who h	ave had				
	current speech therapy	diet recommendation	ons to				
	ensure their current die	et order reflects spee	ch				
	therapy recommendation	ons.					

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			(X2) MULTI	PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	EΥ
	395721		1		10/06/2025	
NAME OF PROVIDER OR SUPPLIER: PARAMOUNT NURSING AND REHABILITATION AT FAYETTEVILLE, LLC STATE LICENSE NUMBER: 420102			ERSBURG	ROAD		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFIC			ID PREFIX TAG	CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETE DATE
tinued from page 35			F 0689			
rapy recommendation ployee 7 will eductor ary orders on her not ober 3, 2025. Inployee 12 (Dietary ary staff currently wares.  I other dietary staff ployee 12 prior to the ude all full time, part I nursing staff currently wares and to read and N Supervisor will extend the ployee 12 (Dietary ary staff currently working on defently working on def	ommendations on spon form and physicial cate Employee 1 on the ext scheduled day to working on diet and working on diet and the start of their shift art-time, and as need ently working in the apployee 6 on diets and follow meal ticket ducate all nursing staticts and diet texture licket directions.  We Manager) audited to any line to ensure meal visually observed in	eech an orders. following o work  cate diet  lucated by a. This will ed staff. building and diet s. aff s and to  conight's eal tickets heal				
	DOR SUPPLIER: NURSING AND REH. ILLE, LLC  BEER: 420102  SUMMARY STATEMENT MUST BE PRECEEDED IDENTIFICATION  tinued from page 35  Imployee 7 will educe capy recommendation imployee 7 will educe ary orders on her new ober 3, 2025. Imployee 12 (Dietary ary staff currently waters.  I other dietary staff ployee 12 prior to to ude all full time, pa I nursing staff current be educated by En ures and to read and N Supervisor will educe tently working on de and follow meal to ming meal service to ched diet order and wrice was accurate.	DOR SUPPLIER: NURSING AND REHABILITATION ILLE, LLC BER: 420102  SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY OF IDENTIFYING INFORMATION)  Itinued from page 35  Imployee 7 will educate speech therapist cedure to write recommendations on sprapy recommendation form and physician phoyee 7 will educate Employee 1 on farry orders on her next scheduled day to ober 3, 2025.  Imployee 12 (Dietary Manager) will educate staff currently working on diet and sures.  I other dietary staff members will be educated all full time, part-time, and as need I nursing staff currently working in the be educated by Employee 6 on diets and sures and to read and follow meal ticket N Supervisor will educate all nursing staff entity working on diets and diet textures and follow meal ticket directions.  Imployee 12 (Dietary Manager) audited to ming meal service tray line to ensure meaning mean	STREET ADDRESS, 6375 CHAMB FAYETTEVII  SER: 420102  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Tinued from page 35  Imployee 7 will educate speech therapists on new cedure to write recommendations on speech rapy recommendation form and physician orders. Imployee 7 will educate Employee 1 on following arry orders on her next scheduled day to work ober 3, 2025.  Imployee 12 (Dietary Manager) will educate arry staff currently working on diet and diet tures.  I other dietary staff members will be educated by ployee 12 prior to the start of their shift. This will ude all full time, part-time, and as needed staff. I nursing staff currently working in the building I be educated by Employee 6 on diets and diet tures and to read and follow meal tickets. N Supervisor will educate all nursing staff rently working on diets and diet textures and to diet and follow meal ticket directions.  Imployee 12 (Dietary Manager) audited tonight's ming meal service tray line to ensure meal tickets ched diet order and visually observed meal	A BLDG: BRITHER STREET ADDRESS, CITY, STATE, Z  STRIET ADDRESS, CITY, STATE, Z  6375 CHAMBERSBURG FAYETTEVILLE, PA 17  BER: 420102  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Tinued from page 35  Inployee 7 will educate speech therapists on new cedure to write recommendations on speech rapy recommendation form and physician orders.  Inployee 7 will educate Employee 1 on following arry orders on her next scheduled day to work ober 3, 2025.  Inployee 12 (Dietary Manager) will educate arry staff currently working on diet and diet ures.  I other dietary staff members will be educated by ployee 12 prior to the start of their shift. This will ude all full time, part-time, and as needed staff.  I nursing staff currently working in the building be educated by Employee 6 on diets and diet ures and to read and follow meal tickets.  N Supervisor will educate all nursing staff rently working on diets and diet textures and to diet and follow meal ticket sures and to diet and follow meal ticket tonight's ning meal service tray line to ensure meal tickets ched diet order and visually observed meal vice was accurate.	DOR SUPPLIER:  NURSING AND REHABILITATION  ILLE, LLC  STREET ADDRESS, CITY, STATE, ZIP CODE.  6375 CHAMBERSBURG ROAD FAYETTEVILLE, PA 17222  SUMMARY STATEMENT OF DEFICIENCIES (BACH) DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Injuded from page 35  F 0689  Imployee 7 will educate speech therapists on new ceedure to write recommendations on speech rapy recommendation form and physician orders. Imployee 7 will educate Employee 1 on following arry orders on her next scheduled day to work ober 3, 2025. Imployee 12 (Dietary Manager) will educate arry staff currently working on diet and diet ures.  I other dietary staff members will be educated by ployee 12 prior to the start of their shift. This will ude all full time, part-time, and as needed staff.  I nursing staff currently working in the building libe educated by Employee 6 on diets and diet ures and to read and follow meal tickets.  N Supervisor will educate all nursing staff rently working on diets and diet textures and to d and follow meal ticket directions. Imployee 12 (Dietary Manager) audited tonight's ning meal service tray line to ensure meal tickets ched diet order and visually observed meal vice was accurate.	DENTIFICATION NUMBER:  395721    A BLDG: 00

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395721		(X2) MULTIPLE CONSTRUCTION:  A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED:  10/06/2025			
PARAMON AT FAYET	VIDER OR SUPPLIER: UNT NURSING AND REH TEVILLE, LLC SE NUMBER: 420102		STREET ADDRESS, CITY, STATE, ZIP CODE: 6375 CHAMBERSBURG ROAD FAYETTEVILLE, PA 17222						
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	(X5) COMPLETE DATE				
F 0689 SS=J	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued from page 36  meal ticket matches diet order and visually observe meal served is accurate.  On October 4, 2025, between 7:45 AM and 8:52 AM, breakfast meal service was observed to ensure all residents received the appropriate texture diet per their physician order. The audit of dinner service on October 3, 2025, as well as the audit of breakfast service on October 4, 2025, were reviewed without concern. Staff interviews revealed the facility had re-educated staff on mechanically altered diets and the choking policy. Interviews were conducted with two registered nurses, two licensed practical nurses, four nursing assistants, two dietary employees, the dietary manager, speech therapist and occupational therapist; all were able to verbalize their role in providing appropriate diet textures.  On October 4, 2025, at 11:35 AM, the Immediate Jeopardy was lifted when the action plan implementation was verified.			F 0689					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395721		(X2) MULTIPLE CONSTRUCTION:  A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 10/06/2025		
NAME OF PROVIDER OR SUPPLIER: PARAMOUNT NURSING AND REHABILITATION AT FAYETTEVILLE, LLC STATE LICENSE NUMBER: 420102			STREET ADDRESS, CITY, STATE, ZIP CODE: 6375 CHAMBERSBURG ROAD FAYETTEVILLE, PA 17222					
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE		
F 0689 SS=J	The facility failed to communicate and follow speech therapy recommendations for bite size pieces for Resident 1, which resulted in Resident 1 choking and subsequent death. This failure placed nine residents that had similar diet needs at a high risk for choking and possible death and resulted in an Immediate Jeopardy situation (Resident 6, 7, 8, 9, 10, 11, 12, 13 and 14).  28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 211.12(c)(d)(1)(2)(3)(5) Nursing services.			F 0689				

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# **Certified End Page**

#### PARAMOUNT NURSING AND REHABILITATION AT FAYETTEVILLE, LLC

STATE LICENSE NUMBER: 420102 SURVEY EXIT DATE: 10/06/2025

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

Jeanne Parisi

Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP Secretary of Health

Debia L. Bogu MD



THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH** 

THIS PAGE IS NOW PART OF THIS SURVEY