

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395785</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>STONEBRIDGE HEALTH &amp; REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>102 CHANDRA DRIVE DUNCANNON, PA 17020</b>		
STATE LICENSE NUMBER: <b>197302</b>				
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F 0000	INITIAL COMMENT	F 0000		
F 0686 SS=D	Based on a Medicare/Medicaid Recertification, State Licensure, and Civil Rights survey completed on July 2, 2025, it was determined that Stonebridge Health and Rehabilitation Center was not in compliance with the following requirements of 42 CFR Part 483 Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0686		

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 0686  SS=D	Continued from page 1  483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer  §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.  This REQUIREMENT is not met as evidenced by:	F 0686	Preparation and submission of this plan of correction does not constitute and admission of, or agreement with, it is required by State and Federal Law. It is executed and executed and implemented as a means to continuously improve the quality of care to comply with the state and federal requirements. 1. Resident 47 had no ill effects from the cited past deficient practice. During the survey, Attending Physician was contacted for clarification, order was obtained to discontinue prevalon boots, care plan was updated. 2. To identify others with the likelihood to be affected, the DON/designee completed a house-wide audit of care plans/orders to identify all residents ordered prevalon boots. Assessments were completed on all the Residents identified, need for prevalon boot was reviewed with MD, and care plan was updated with any further recommendations received. 3. To prevent a future	Completion Date: <b>07/17/2025</b> Status: <b>APPROVED</b> Date: <b>07/14/2025</b>

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F 0686  SS=D	Continued from page 2	F 0686	<p>reoccurrence, the DON/designee will educate all nursing staff to ensure documentation completed for a Resident reflects the plan of care observed in place.</p> <p>4. To monitor and maintain ongoing compliance, the DON/designee will audit 5 random residents with a care plan approach for prevalon boots observing that documentation completed reflects the plan of care visualized in place, weekly x 4 and then monthly x 2. Any inaccurate findings will be corrected immediately, and findings will be reported to the QA committee monthly, for any further necessary recommendations.</p>	

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F 0686  SS=D	Continued from page 3  Based on observations, clinical record review, and staff interview, it was determined that the facility failed to ensure that residents receive necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent infection of a pressure ulcer for one of 16 residents reviewed (Resident 47).  Findings include:  Review of Resident 47's clinical record revealed diagnoses that included chronic kidney disease (a gradual loss of kidney function) and hyperlipidemia (high levels of fat in the blood).  Review of Resident 47's clinical record revealed an active physician's order for prevalon boots on at all times every shift, with a start date of October 9, 2024.  Observations of Resident 47 on June 30, 2025, at 12:15 PM and 2:16 PM, revealed the Resident was sitting in their wheelchair wearing sneakers instead	F 0686		

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F 0686  SS=D	<p>Continued from page 4</p> <p>of prevalon boots.</p> <p>Observation of Resident 47 on July 1, 2025, at 12:03 PM and 2:26 PM, revealed the Resident sitting in their wheelchair wearing sneakers instead of prevalon boots.</p> <p>Review of Resident 47's Medication Administration Record (MAR) for June 30, 2025, revealed that Resident 47 was marked off as having prevalon boots on during day, evening, and night shift.</p> <p>Review of Resident 47's MAR for July 2025, revealed the Resident was marked off as having her prevalon boots on during the day shift.</p> <p>Review of Resident 47's comprehensive care plan revealed a problem area for skin integrity, that the Resident is at risk for impaired skin integrity related to impaired mobility, cognitive deficits, incontinence, depression, and prescribed medications, with a problem start date of August 14, 2024, and an edited date of November 13, 2024. Further review</p>	F 0686		

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F 0686  SS=D	<p>Continued from page 5</p> <p>of Resident 47's care plan revealed an approach area to wear prevalon boots at all times, with a start date of August 21, 2024, and an edited date of October 10, 2024.</p> <p>Review of Resident 47's clinical record revealed the Resident had a consult with a foot and ankle doctor on October 9, 2024, who gave the recommendation for the Resident to wear a prevalon boot to right foot daily at all times.</p> <p>Review of Resident 47's clinical record revealed a nursing progress note written on July 2, 2025, at 8:55 AM, with the following text: after reviewing prevalon boot order for the resident, the resident had heel skin alteration when admitted and prevalon boots were in place for this - heels are now completed healed and resolved. Family had provided shoes after heels healed that they wanted the resident to wear.</p> <p>Review of Resident 47's clinical record revealed the Resident had a stage 3 pressure wound to their right</p>	F 0686		

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F 0686  SS=D	Continued from page 6  heel that has been resolved as of November 13, 2024.  Review of Resident 47's clinical record on July 2, 2025, at 11:30 AM, revealed the order for prevalon boots was removed as well as the approach area on their care plan to wear prevalon boots at all times.  Review of Resident 47's clinical record failed to indicate that the Resident or family preferred Resident 47 to wear the sneakers that were provided by the family daily instead of the prevalon boots that were ordered and recommended from the physician prior to July 2, 2025.  Interview conducted with the Nursing Home Administer on July 2, 2025, at 11:41 AM, revealed he would have expected staff not to be documenting Resident 47 wearing prevalon boots if they were not, Resident 47's physician order to have been updated, and the care plan to have been updated at the time the family requested the Resident to wear shoes they brought in for her instead of prevalon	F 0686		

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F 0686  SS=D	Continued from page 7  boots.  28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0686		
F 0688  SS=D		F 0688		

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F 0688  SS=D	Continued from page 8  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	Preparation and submission of this plan of correction does not constitute and admission of, or agreement with, it is required by State and Federal Law. It is executed and executed and implemented as a means to continuously improve the quality of care to comply with the state and federal requirements. 1. Resident 48 had no ill effects from the cited past deficient practice. During the survey, Attending Physician was contacted for clarification, order was obtained to remove splint on left hand, care plan was updated 2. To identify others with the likelihood to be affected, the DON/designee completed a house-wide audit to identify all residents ordered splints. Assessments were completed on all Residents identified, to ensure any splints ordered are in place and not causing skin impairment. Splint was reviewed with the therapy dept and attending physician, plan of care was updated reflecting any further recommendations received.	Completion Date: <b>07/17/2025</b> Status: <b>APPROVED</b> Date: <b>07/14/2025</b>

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F 0688  SS=D	Continued from page 9	F 0688	<p>3. To prevent a future reoccurrence the DON/designee will educate all nursing staff to ensure documentation completed on splinting for a Resident reflects the plan of care observed in place, and follows physician orders. If splint is held by physician, order will be transcribed to current plan of care ordered.</p> <p>4. To monitor and maintain ongoing compliance the DON/designee will audit 5 random residents with splints to ensure Resident is free of skin impairment related to splint, and the documentation completed reflects plan of care observed, weekly x 4 weeks and then monthly x2. Any inaccurate findings will be corrected immediately, and findings will be reported to the QA committee monthly, for any further recommendations.</p>	

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F 0688  SS=D	Continued from page 10  Based on observations, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure residents with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility for one of three residents reviewed for mobility (Resident 48).  Findings Include:  Review of Resident 48's clinical record revealed diagnoses that included stroke and elevated blood pressure.  Review of Resident 48's current physician orders revealed an order, with a start date of October 15, 2024, for left hand splint, on at all times, may remove for care and to remove splint every shift to observe and monitor for skin breakdown.  Review of Resident 48's current care plan revealed left hand splint on at all times, remove splint every shift and observe and monitor for skin breakdown,	F 0688		

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F 0688  SS=D	<p>Continued from page 11</p> <p>dated October 15, 2024.</p> <p>Observations of Resident 48 on June 30, 2025, at 10:14 AM, 12:37 PM, 1:39 PM, and on July 1, 2025, at 11:04 AM and 12:05 PM, revealed Resident 48's left hand splint was not in place.</p> <p>During an interview with Resident 48 on July 1, 2025, at 11:04 AM, Resident 48 stated that she does have a splint but "they haven't put it on." At this time, a black splint was observed in a basket on Resident 48's bedside dresser.</p> <p>Review of Resident 48's Medication Administration Record (MAR) dated June 2025, revealed that Resident 48's splint was signed off as being on, on each shift, each day, with the exception of night shift on June 6 and 9, and evening shift on June 24 and 28. It was signed off as being refused by the Resident on those shifts.</p> <p>Review of Resident 48's MAR for July 2025, revealed the splint was signed off as being on on day</p>	F 0688		

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F 0688  SS=D	Continued from page 12  shift on July 1, 2025.  During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on July 2, 2025, at 10:20 AM, the DON stated that on May 1, 2025, there is a progress note stating that the splint was put on hold due to swelling and that therapy discontinued the splint. The DON also stated she was unable to state why staff were documenting placement of the splint, when it was not applied.  Review of Resident 48's nursing progress notes revealed a note on May 1, 2025, at 12:02 AM, stating that the Resident's hand splint was on hold due to swelling.  Review of Resident 48's nursing progress note on May 1, 2025, at 11:35 AM, revealed that the left hand swelling had decreased, the splint was in place and the Resident was tolerating it well.  Review of additional nursing progress notes on May	F 0688		

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F 0688  SS=D	Continued from page 13  2, 2025, at 2:30 PM and 6:02 PM, revealed documentation that Resident 48's splint was in place.  Review of Resident 48's Occupational Therapy (OT) evaluation and plan of treatment, dated June 3, 2025, revealed to continue with left hand wrist/forearm resting hand splint.  Review of Resident 48's facility form titled "Rehabilitation Services Screening", dated July 1, 2025, revealed that OT was discontinued on June 30, 2025, and the left hand splint is not needed.  Review of a nursing progress note dated July 2, 2025, at 8:51 AM, revealed that, in speaking with the director of rehab, the splint has been discontinued due to swelling and increase in pressure caused by the splint.  There is no evidence that the splint was to be discontinued prior to July 1, 2025, and no orders for the splint to be put on hold.	F 0688		

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F 0688  SS=D	Continued from page 14  In a follow-up interview with the NHA and DON on July 2, 2025, at 11:35 AM, no additional information was provided.  28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0688		
F 0880  SS=E		F 0880		

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NAME OF PROVIDER OR SUPPLIER: <b>STONEBRIDGE HEALTH &amp; REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>197302</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>102 CHANDRA DRIVE DUNCANNON, PA 17020</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0880  SS=E	Continued from page 15  483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control  §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.  §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;  §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	Preparation and submission of this plan of correction does not constitute and admission of, or agreement with, it is required by State and Federal Law. It is executed and executed and implemented as a means to continuously improve the quality of care to comply with the state and federal requirements. 1. -Residents 18 and 38 had an assessment completed, no ill effects were identified from the cited past deficient med administration practice. -Resident 44 had an assessment completed, no ill effects were identified from the cited past deficient practice regarding failure to follow enhanced barrier precautions. -There were no residents affected by the cited past deficient practice r/t incomplete Antibiotic Use Tracking Logs. 2. -All residents have the potential to be affected by the cited past deficient medication administration practice. -To identify others with the likelihood to be affected, the	Completion Date: <b>07/17/2025</b> Status: <b>APPROVED</b> Date: <b>07/14/2025</b>

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F 0880  SS=E	Continued from page 16  (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.  §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.  §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.  §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.  This REQUIREMENT is not met as evidenced by:	F 0880	DON/designee completed a house-wide audit to ensure all residents that require enhanced barrier precautions have an order, signage, and an isolation caddy is present containing necessary PPE, any missing necessary items will be immediately corrected. -To identify others with the likelihood to be affected, the DON/designee completed an antibiotic order audit from Date of exit to present, ensuring that all new antibiotic orders are captured on the Antibiotic Use Tracking Log, the log will be updated with any orders that were inadvertently missed. 3. -To prevent a future reoccurrence the DON/designee will educate all licensed staff on the proper pouring of medications during med pass, ensuring medications do not come in contact with any other surface except the inside of the medication cup. -To prevent a future reoccurrence the DON/designee will educate all licensed nursing staff on the conditions that require enhanced	

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F 0880  SS=E	Continued from page 17	F 0880	<p>barrier precautions, to ensure an order, signage and an isolation caddy is present reflecting same.</p> <p>- To prevent a future reoccurrence the DON/designee will educate The Infection Preventionist on the proper completion of the Antibiotic Use Tracking Log.</p> <p>4. -To monitor and maintain ongoing compliance, the DON/designee will observe 3 Random Licensed Nurses administering medications to one Resident, ensuring medications poured during med pass do not come in contact with any other surface except the inside of the medication cup, any deficient practice identified will be immediately corrected, weekly x 4 and them monthly x 2.</p> <p>-To monitor and maintain ongoing compliance the DON/designee will audit 5 random residents requiring enhanced barrier precautions, ensuring an order, signage and isolation caddy are present, any missing items will be immediately corrected, weekly x 4 and then</p>	

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F 0880  SS=E	Continued from page 18	F 0880	<p>monthly x 2.</p> <p>- To monitor and maintain ongoing compliance, the DON/designee will complete an audit of 3 Random antibiotics ordered, ensuring the necessary information is present on the Antibiotic Use Tracking Log for the initiation of the antibiotic, any missing information will be immediately corrected weekly x 4, and then monthly x 2. All findings will be reported to the QA committee monthly for any further necessary recommendations.</p>	

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F 0880  SS=E	Continued from page 19  Based on observations, facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to maintain an effective infection control program related to the preparation and administration of medications for two of two residents observed; failed to ensure staff implemented infection control policies to prevent the spread of infection for one of 19 residents reviewed; and failed to maintain an accurate data collection system of infection surveillance from October 2024 through March 2025.  Findings Include:  Review of facility policy, titled "6.0 General Dose Preparation and Medication Administration," last revised November 15, 2024, revealed it stated, "1.2 Medications should not come in contact with any surface except for the medication cup ...2.3 Facility staff should avoid touching the medication with bare hands when opening a bottle or unit dose package ..."	F 0880		

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F 0880  SS=E	Continued from page 20  Review of facility policy, titled "Enhanced Barrier Precautions (EBP) Policy", revised May 19, 2025, revealed "EBP are intended to prevent transmission of multi-drug-resistant organisms (MDROs) via contaminated hands and clothing of healthcare workers to high-risk residents during high contact activities."  The policy further stated, in part, that high-risk residents include those with chronic wounds and high contact care activities include wound care.  Further review of the policy revealed "Staff engaging in high-contact activities will don both gloves and gown before initiating the activity..." and that a sign will be placed on the resident's door indicating the appropriate type(s) of precautions.  During medication administration observation on July 1, 2025, between approximately 8:54 AM and 9:10 AM, Employee 1 (Licensed Practical Nurse) was observed preparing and administering medications to Residents 18 and 38.	F 0880		

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F 0880  SS=E	Continued from page 21  During the medication preparation for Resident 18, Employee 1 was observed dispensing a medication from the medication card (tablets packed in individual blisters with paper backs to be punched out during preparation) directly to Employee 1's bare hand and then into the medication cup.  During medication preparation for Resident 38, Employee 1 was observed dispensing a medication from the medication card, the medication tablet landed on the fingers of Employee 1's left hand, at which time Employee 1 dropped the medication tablet into the medication cup.  During a staff interview on July 2, 2025, at approximately 11:40 AM, Nursing Home Administrator (NHA) confirmed that staff should follow the facility's policy on medication preparation and administration and not touch medications with their bare hands.  Review of Resident 44's clinical record revealed	F 0880		

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F 0880  SS=E	<p>Continued from page 22</p> <p>diagnoses that included an unstageable pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) to the sacrum (triangular bone at the base of the spine) and hypertension (elevated blood pressure).</p> <p>Observation of Resident 44's room on June 30, 2025, at 9:47 AM, and July 1, 2025, at 9:59 AM, revealed no signage on Resident 44's door indicating that Resident 44 was on EBP.</p> <p>Observation of Resident 44's wound care to her pressure ulcer, on July 1, 2025, at 10:00 AM, revealed Employee 2 wearing gloves, but no gown, while performing Resident 44's wound care.</p> <p>At the conclusion of Resident 44's wound care, Employee 2 was asked if Resident 44 should be on EBP. Employee 2 stated that she thought she should have worn a gown, but there was no sign on Resident 44's door for EBP.</p> <p>Observation of Resident 44's room on July 1, 2025,</p>	F 0880		

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F 0880  SS=E	<p>Continued from page 23</p> <p>at 11:06 AM, revealed a sign had been placed on Resident 44's door, indicating she was on EBP.</p> <p>During an interview with the NHA and Director of Nursing (DON) on July 1, 2025, at 1:04 PM, the DON confirmed that Resident 44 should have been on EBP and a gown should have been worn during Resident 44's wound care.</p> <p>Review of facility form, titled "Antibiotic Use Tracking Log", revealed data to be collected and documented each month included, in part, resident's name and room number, admission date, infection type, onset date, signs and symptoms, how/where the infection was acquired, labs, imaging, antibiotic information, and any isolation.</p> <p>Review of the facility's Antibiotic Use Tracking Log forms for August 2024 through June 2025, revealed no tracking was completed for October 2024 through March 2025.</p> <p>During an interview with the NHA and DON on</p>	F 0880		

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F 0880  SS=E	Continued from page 24  July 2, 2025, at 11:36 AM, the DON confirmed that the Antibiotic Use Tracking Log form was not completed for the months of October 2024 through March 2025.  28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28. Pa Code 211.12(d)(1)(2)(5) Nursing services	F 0880		



# Certified End Page

**STONEBRIDGE HEALTH & REHABILITATION CENTER**

**STATE LICENSE NUMBER: 197302**

**SURVEY EXIT DATE: 07/02/2025**

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

  
Jeanne Parisi  
Deputy Secretary for Quality Assurance

  
Debra L. Bogen, MD, FAAP  
Secretary of Health



**Pennsylvania  
Department of Health**

THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY