STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395791	A. BLDG: 00 B. WING:	04/25/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
COMPLETE CARE AT HARSTON HALL LLC STATE LICENSE NUMBER: **080702**	**350 HAWS LANE** **FLOURTOWN, PA 19031**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance survey and an Abbreviated survey in response to three complaints, completed April 25, 2025, it was determined that Complete Care at Harston Hall LLC was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations as they relate to the Health portion of the survey.	F 0000		

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 0550 SS=D	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the	F 0550	A – Staff E10, E5, and E9 issued identification badges. B – All staff checked for identification badges and new identification badges were issued to any staff missing a badge. C – Staff educated on importance of wearing identification badges during shift. Staff educated on placing badge in an easily invisible area. D – Weekly x 4 then monthly x 2 audits by DON or designee of staff during a shift for presence of identification badge during shift worked. Results will be discussed in QAPI meetings.	Completion Date: **06/23/2025** Status: **APPROVED** Date: **05/22/2025**

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F 0550 SS=D	Continued from page 2 facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by:	F 0550		

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F 0550 SS=D	Continued from page 3 Based on observations, review of facility policy and interviews with residents, it was determined that the facility failed to promote and maintain dignity and respect for two of 24 residents reviewed (Resident R100 and R40). Findings include: Review of facility policy "Promoting/ Maintaining Resident Dignity", implemented on September 1, 2024, revealed it is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Under Compliance guidelines, all staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. Review of Resident R100's clinical record revealed that Resident R100 was admitted to the facility on	F 0550		

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F 0550 SS=D	Continued from page 4 September 22, 2023 with diagnoses of, but not limited to, Parkinson's Disease (movement disorder that affects the nervous system and worsens over time) and Type 2 Diabetes (failure of the body to produce insulin). Review of Resident R100's Minimum Data Set (MDS- assessment of resident care needs) revealed that Resident R11 had a BIMS (Brief interview for mental status) of 13, which indicated that the resident was cognitively intact. Interview with Resident R100 on April 22, 2025 at 11:32 am revealed resident felt staff was constantly disrespectful, refused to give their names or showed their identification upon request. The resident felt staff was "mean" to him and gave him a hard time when he asked for assistance. Review of Resident R40 's clinical record revealed that Resident R40 was admitted to the facility on January 18, 2021 with diagnosis of, but not limited to, left femur fracture, Type 2 diabetes, heart	F 0550		

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F 0550 SS=D	Continued from page 5 disease. Review of Resident R40 's MDS revealed that the resident has a BIMS of 12, indicating resident was cognitively intact. Interview with Resident R40 on April 22, 2025 at 11:40am revealed resident felt that staff was disrespectful. Staff woke resident up in the middle of the night without explanation, did not answer questions when asked, talked down to the resident. Resident stated that there was no way to identify staff, they did not wear name tags, if you ask the name of a staff member, they become very defensive and hostile and refuse to give their name. Staff told resident "If you want the name you have to talk to administration." Observation of staff on April 23, 2025 at 09:45 am, revealed Licensed nurse, Employee E10, identification badge not clearly displayed (badge hidden behind other cards).	F 0550		

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F 0550 SS=D	Continued from page 6 Observation of Staff on April 24, 2025 at 09:23 am revealed Licnesed nurse, Employee E9 not wearing identification badge. Observation of Staff on April 24, 2025 09:26 am revealed Licensed nurse, Employee E5, identification badge not clearly displayed (Badge on lanyard behind multiple other cards). 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.29 (j) Resident rights	F 0550		
F 0584 SS=E		F 0584		

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F 0584 SS=E	Continued from page 7 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	A – Room 304 was cleaned and sanitized upon notification. B – All resident rooms given a deep clean of bedside dressers, tray tables, and windowsills. All discharged resident rooms cleaned and sanitized. C – Director of housekeeping and housekeeping staff educated on cleaning of bedside dressers, tray tables, and windowsills in resident rooms and all discharged resident rooms will be cleaned and sanitized within 24 hours D- Weekly x 4 then monthly x 2 audits by the Director of Housekeeping or designee to ensure beside dressers, tray tables, and windowsills are clean and free of dust and all discharged resident rooms will be cleaned and sanitized within 24 hours. Results discussed during QAPI meetings.	Completion Date: 06/23/2025 Status: APPROVED Date: 05/22/2025

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F 0584 SS=E	Continued from page 8 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584		

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F 0584 SS=E	Continued from page 9 Based on facility policy and observations, it was determined that the facility failed to provide a sanitary, clean, comfortable, homelike environment for one out the two units observed. (Third floor nursing unit). Findings include: A review of the policy titled " Home Environment" revised on July 1, 2024, under the Policy Guidelines #3 " Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment". On April 22, 2025, at 12:51 p.m. observation of room 304B had a significant urine smell. On April 24, 2025, an observation of Room 304A revealed that Resident R10, who had passed away on April 22, 2025, had not had her room cleaned or cleared. Her personal belongings remained in place, including her reclining chair, which, according to Licensed Nurse Employee E6, was broken and	F 0584		

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F 0584 SS=E	Continued from page 10 being used to store random items. The items included ankle protectors and uncovered pillows. Both bedside dressers were covered with a noticeable layer of dust. Resident R10 had two dressers, and behind one of them, a broken television was stored alongside additional ankle protectors. Dried-out flowers were also present, contributing to dirt and debris on the floor and on top of the television stand. Observations conducted of Room 304, revealed that four bedside dressers were dusty, tray tables had visible food spills, and the windowsills were also dusty and had not been cleaned. These findings were confirmed by Licensed Nurse Employee E6. On April 25, 2025, at approximately 10:30 a.m., a meeting with the Administrator, Employee E1, it was confirmed that housekeeping staff are not consistently maintaining resident rooms, including regularly dusting dressers and wiping tray tables. On April 25, 2025, at 2:30 p.m., a second	F 0584		

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F 0584 SS=E	Continued from page 11 observation was conducted with the Housekeeping Supervisor, Employee E4, who confirmed that Room 304A had not been cleaned or sanitized since the passing of Resident R10 on April 22, 2025. 28 Pa. Code 201.18(b)(1) Management	F 0584		
F 0602 SS=E		F 0602		

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F 0602 SS=E	Continued from page 12 483.12 Free from Misappropriation/Exploitation §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by:	F 0602	A – Resident R262 expired and cannot be corrected. Resident R69 had a replacement bottle of morphine ordered and charged to the facility. B – Audit of all incidents of misappropriation of narcotics in last 30 days to ensure facility replaced medication at facility's cost. C – Previous DON and NHA educated on process of replacing any misappropriated narcotic medications at the cost of the facility. Current DON and NHA are aware of this process. D – Weekly x 4 then monthly x 2 audits by DON or designee of misappropriated narcotic medications to ensure replacement at the cost of the facility. Results discussed during QAPI meetings.	Completion Date: **06/23/2025** Status: **APPROVED** Date: **05/22/2025**

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F 0602 SS=E	Continued from page 13 Based on review of clinical records, and interviews with staff and residents, it was determined that the facility did not ensure that residents were free of misappropriation of resident property related to diversion of narcotic medication for two of 24 residents records reviewed (residents R69 and R262). Findings include: Review of clinical documentation for Resident R69 revealed that she was admitted to the facility on December 12, 2019, and had diagnoses including of dementia (progressive degenerative disease of the brain), chronic pain and arthritis (join inflamation). Conintued review of the resident's clinical record revealed that the resident signed on to receive hospice care in February 2024. Review of Resident R69's May 2025 physican orders revealed an order obatined dated May 22, 2024, for "Morphine sulphate ...20MG (milligrams)/ML ...give 0.25 ml by mouth every four	F 0602		

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F 0602 SS=E	Continued from page 14 hours as needed for pain". Review of her most recent MDS (Minimum Data Set, a periodic assessment of resident care needs) section C, Cognitive Patterns, dated April 7, 2025, revealed that the resident had a BIMS (Brief Interview for Mental Status, an assessment of orientation and memory recall) score of 9 out of 15, indicating moderate impairment. Review of clinical documentation for Resident R262 revealed that she was admitted to the facility on July 17, 2013, and had diagnoses including, but not limited to, dementia, chronic pain and arthritis. Further review showed that she signed on for hospice care on August 7, 2023. A physician order, dated August 23, 2023, was noted which stated, "Morphine sulphate ...20MG/ML ...give 0.25 ml by mouth every 6 hours as needed for SOB (shortness of breath)/pain". Review of records also revealed that the resident had died on November 11, 2024. Review of a facility reported incident from October	F 0602		

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F 0602 SS=E	Continued from page 15 14, 2024, revealed that on that date, licensed nurse Employee E32, upon administering a dose of morphine to resident R262, noted that the color of the liquid in the bottle was a paler blue than usual. She also noted a mint-like smell to the liquid, and that the bottle cap was incorrect. On further investigation, it was noted by the facility that the color, smell, and bottle cap were all consistent with the facility house stock mouthwash. An investigation was initiated, and all liquid morphine in the facility was reviewed for signs of tampering. The morphine bottle for resident R69 was also found to be altered in color and to have a "minty" smell. No other morphines were noted to appear to be tampered with. An email dated October 16, 2024, stated that independent laboratory testing confirmed that the concentration of the morphine for resident R262 was 3.88 MG/ML, confirming that it had been diluted. Interview with Resident R69 on April 24, 2025, at 1:15 p.m. revealed that she felt that her pain management had been adequate and that she did not	F 0602		

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F 0602 SS=E	Continued from page 16 suffer an increase in pain related to the morphine diversion. At the time of the interview, the resident was alert and oriented. Interview with the Nursing Home Administrator, Employee E1, and the Director of Nursing, Employee E2, on April 24, 2025, at 2:30 p.m. confirmed that the Morphine for Residents R69 and R262 had been misappropriated. Employee E1 stated that all nurses with access to the medication had been tested for opiates; all nurses tested negative. He further stated that the local police department had been contacted but had declined to investigate the matter. 28 Pa. Code 201.14(a)(b) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(2)(3) Management 28 Pa. Code 201.29(a) Resident rights	F 0602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395791	A. BLDG: 00 B. WING:	04/25/2025

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COMPLETE CARE AT HARSTON HALL LLC STATE LICENSE NUMBER: **080702**	**350 HAWS LANE** **FLOURTOWN, PA 19031**

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F 0602 SS=E	Continued from page 17	F 0602		
F 0607 SS=D	483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.	F 0607	A – Employees identified E26 and E30 are already hired and have background checks completed. B – Audit of all current employees to ensure a background check was completed. C – Educate HR that all new hires require a background check completed prior to official hire date. D – Weekly x 4 then monthly x 2 audits by DON or designee of all new hires to ensure background check completed prior to hire date. Results discussed during QAPI meetings.	Completion Date: **06/23/2025** Status: **APPROVED** Date: **05/22/2025**

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F 0607 SS=D	Continued from page 18 §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by:	F 0607		

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F 0607 SS=D	Continued from page 19 Based on a review of facility policies and procedures, employee personnel records, and staff interviews, it was determined that the facility failed to develop and implement an abuse prohibition policy that required a thorough investigation of prospective employees' employment history for two of six newly hired employees reviewed. (Employees E26 and E29) Findings include: A review of the Facility Policy titled " Abuse" revised on June 30, 2023, revealed Centers prohibit abuse, mistreatment, neglect, misappropriation of resident/ patient (hereinafter "patient"), and exploitation for all patients. The center will implement an abuse prohibition program through the following: Screening of potential hires: training of employees (both new employees and ongoing training for all employees." A review of the Licensed Practical Nurse (LPN), Employee E26's personnel file revealed that	F 0607		

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F 0607 SS=D	Continued from page 20 Employee E26 was hired on March 1, 2025, and criminal background was done April 1, 2025. Register nurse (RN), Employee E29 was hired on January 1, 2025, and had her criminal background done on January 8, 2025. An interview was conducted with Human Resources, staff, Employee E30 on April 25, 2025, sat 1:42 p.m., it was confirmed both LPN, Employee E26 and RN, Employee E29 had their criminal background done after their hire date. 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 201.19 Personnel policies and procedures	F 0607		
F 0610 SS=D		F 0610		

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F 0610 SS=D	Continued from page 21 483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0610	A – Employee E14 was terminated following incident. Unable to complete investigation further at this time due to time lapse since incident. B – All allegations of abuse or neglect in last 30 days reviewed to ensure completion of investigation. C – Previous DON and NHA educated on Investigation process with completion of investigation including witness statements from all possible witnesses. Current DON and NHA are aware of the process for investigation. D – weekly x 4 then monthly x 2 audits by DON or designee of abuse and neglect investigations to ensure completeness of investigation. Results discussed during QAPI meetings.	Completion Date: 06/23/2025 Status: APPROVED Date: 05/22/2025

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F 0610 SS=D	Continued from page 22 Based on review of clinical records, facility policies and interviews with staff, it was determined that the facility failed to conduct a complete and thorough investigation of one incident related to the provision of incontinence care for one of 23 residents reviewed. (Resident R 30). Findings include: Reviewed the facility policy title Abuse date on June 30, 2023 stated " Centers prohibit abuse, mistreatment, neglect, misappropriation of resident/ patient (hereinafter "patient") property, and exploitation for a patients. Neglect is the failure of the facility, its employees or service providers to provide goods and service to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of Resident R30's clinical record revealed that the resident was admitted to the facility on January 13, 2023, with a BIMS (Brief interview for	F 0610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0610 SS=D	Continued from page 23 mental status) of 8 and diagnosies of Alzheimer's Disease (progressive degenerative disease of the brain), encephalopathy (disease that affects the brain function or structure), Parkinson's disease (progressive disease of the central nervous system), and Angina (chest pain). Review of the facility investigation report revealed that Resident R30 had his call bell on approximately at 1:45 pm on June 11, 2024, nurse manger entered room to answer call bell and found the resident with wet sheets. The resident stated that he had not been changed, there were darker stains on the sheet. Resident R30 stated he did not know when he was changed last. The nurse manager asked resident's roommate if he was cared for, he stated he was changed but did not remember what time. Furthermore, after review of interview with staff, time of incident was between 1:00-2:00 PM on June 11, 2024 after multiple discussion with staff on the unit 7-3 on June 6, 2025, it was determined that nurse aide Employee E31 did infact did not	F 0610		

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F 0610 SS=D	Continued from page 24 complete the 2 hour round and check and change of Resident R30 who was assigned to her. Review the investigation it was revealed that investigation was incomplete. It only had one statement from the nurse Employee E14. The incident had more staff and residents interviewed but the investigation didn't have any other witness statements from nursing aides, other staff and residents. An interview was held with director of nursing employee E2 on April 23, 2025, at 2:33 p.m., and it was confirmed that the investigation was incomplete due to missing witness statements from other staff and residents. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services	F 0610		

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F 0610 SS=D	Continued from page 25	F 0610		
F 0656 SS=D	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 0656	A – Resident R10 had a comprehensive care plan added for oxygen use. Resident R73 had a comprehensive care plan added for safety and elopement. Resident R82 had a comprehensive care plan added for repositioning. B – All residents requiring oxygen, at risk for elopement, and requiring a repositioning program audited to ensure comprehensive care plan in place for oxygen use, elopement risk, and repositioning program. C – Staff educated on completion of comprehensive care plans for oxygen use, elopement risk, and repositioning programs D – weekly x 4 then monthly x 2 audits by DON or designee of comprehensive care plans for new resident needs for oxygen use, elopement risk, and repositioning programs. Results discussed during QAPI meetings.	Completion Date: **06/23/2025** Status: **APPROVED** Date: **05/22/2025**

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F 0656 SS=D	Continued from page 26 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656		

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F 0656 SS=D	Continued from page 27 Based on review of facility policies and clinical records, and staff interviews, it was determined that the facility failed to develop comprehensive care plans for oxygen therapy (Resident 10), a safety device and elopement (Resident R73) and a repositioning program (Resident R82) for three of 23 residents reviewed (Resident R10, R73, R82). Findings include: A review of the policy titled " Comprehensive Care Plans" dated February 25, 2025 revealed " It is the policy of this facility to develop and implement a comprehensive person-centered care plan or each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality". Review of Resident R10's clinical record revealed that the resident was initially admitted to the facility	F 0656		

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F 0656 SS=D	Continued from page 28 on August 11, 2015; diagnosed with emphysema (chronic lung condition), dyspnea (shortness of breath). Review of clinical record indicated that Resident R10 was ordered, dated March 25, 2025, oxygen at 2 Liters/Min, via nasal cannula, as needed for diagnosis of dyspnea (shortness of breath). Review of Resident R10's care plan with Registered nurse, Employee E5 confirmed that there was no care plan plan developed for the resident receiving oxygen therapy. A review of the clinical record for Resident R73 revealed that she/he was admitted to the facility on October 2, 2021, and was at risk for elopement. The physician order dated March 18, 2025, revealed a safety device (wander guard) to left ankle -check placement. On April 23, 2025, at approximately 2:37 p.m. an interview with the Directive of Nursing, Employee	F 0656		

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F 0656 SS=D	Continued from page 29 E2, confirmed that Resident R73 did not have a care plan for the safety device and/or for being at risk for elopment. Review of facility policy "Turning and repositioning", implemented on September 1, 2024, revealed all residents at risk of, or with existing pressure injuries, will be turned and repositioned, unless it is contraindicated due to medical condition. The frequency of turning and repositioning will be documented in the resident's plan of care. Review of Resident R82 's clinical record revealed that Resident R82 was admitted to the facility on April 27, 2023 with diagnoses of, but not limited to, Dementia (progressive degenerative disease of the brain), Heart failure, Type 2 Diabetes (failure of the body to produce insulin) and Acute Kidney failure. Review of Resident R82' s MDS (Minimum Data Set- resident assessment of care needs) revealed that resident had a BIMS (Brief interview for mental status) of 6, indicating resident was not cognitively	F 0656		

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F 0656 SS=D	Continued from page 30 intact. Review of Resident R82's clinical record revealed Resident R82 has a Stage III (ulcer involving full thickness of skin loss) pressure ulcer on right buttocks that initially presented on March 10, 2025 as a DTI (deep tissue injury) and a Stage III pressure ulcer on sacrum that initially presented on March 3, 2025 as a MASD (Moisture associated skin damage). Interview with Rehab Director, Employee E11 on April 23, 2025 at 1:45 pm revealed that Resident R82 needed to be prompted to be repositioned, otherwise the resident would not be able to do it himself. Review of Resident R82 's care plan revealed Resident R82 had the potential impairment to skin integrity related to fragile skin, decrease mobility, aging, incontinence, history of weight loss. No documented evidence of care plan for resident to be turned and repositioned.	F 0656		

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F 0656 SS=D	Continued from page 31 Interview with Director of Nursing, Employee E2 on April 23, 2025 at 2:00 pm revealed no care plan in place for turning and positioning for Resident R82. 28 Pa. Code 211.12(d)(1)(5) Nursing services 28 Pa. Code 211.10(c)(d) Resident care policies	F 0656		
F 0677 SS=D		F 0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0677 SS=D	Continued from page 32 483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 0677	A – Resident R24 had their fingernails cleaned and trimmed. B – An audit of all dependent residents was completed to ensure fingernails were cleaned and trimmed. C – Staff educated on providing proper fingernail care to dependent residents D – Weekly x 4 then monthly x 2 audits completed by DON or designee on all dependent residents to ensure fingernails are clean and trimmed. Results discussed during QAPI meetings.	Completion Date: **06/23/2025** Status: **APPROVED** Date: **05/22/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395791	A. BLDG: __00_____ B. WING: _____	04/25/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
COMPLETE CARE AT HARSTON HALL LLC STATE LICENSE NUMBER: 080702	350 HAWS LANE FLOURTOWN, PA 19031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0677 SS=D	Continued from page 33 Based on review of facility policies and clinical records, and staff interviews, it was determined that the facility failed to provide activities of daily living (ADL) assistance necessary to maintaining good grooming for one out of 4 residents reviewed. (Resident 24) Findings include: A review of the clinical record of Resident R24 revealed admission date of August 31, 2022, with diagnosis of chronic atrial fibrillation (irregular rapid heart beat), osteoarthritis, adult failure to thrive, low back pain. Review of Resident R24's quarterly MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated March 7, 2025, revealed a Brief Interview for Mental Status (BIMS- is a screening test that aides in detecting cognitive impairment) indicated a score of 13 which revealed that the resident was cognitively intact. The section of Functional Abilities indicated that Resident R24	F 0677		

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COMPLETE CARE AT HARSTON HALL LLC STATE LICENSE NUMBER: **080702**	**350 HAWS LANE FLOURTOWN, PA 19031**

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F 0677 SS=D	Continued from page 34 requires maximum assist with personal hygiene. On April 22, 2025, at 12:00 p.m., an observation conducted with Licensed Nurse Employee E12 confirmed that Resident R24 had long and dirty fingernails. Resident R24 expressed a desire to have his fingernails trimmed. On April 23, 2025, at 12:39 p.m., a second observation with Licensed Nurse Employee E12 revealed that Resident R24's right thumbnail remained untrimmed and dirty. Employee E12 stated she was unsure why all the resident's nails had not been cut. 28 Pa Code 211.12(d)(5) Nursing services	F 0677		

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F 0686 SS=D	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	A – Resident R106 has been discharged from the facility. B – Audit of all residents with have orders for pressure relieving devices to the heels to ensure device in place. C – All nursing staff educated on pressure wound prevention devices for the heels. D – Weekly x 4 then Monthly x 2 audits by DON or designee of pressure wound prevention devices for the heels to ensure compliance with interventions/orders. Results discussed during QAPI meetings.	Completion Date: **06/23/2025** Status: **APPROVED** Date: **05/22/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0686 SS=D	Continued from page 36 Based on review of facility policy, review of clinical record, and staff interview, it was determined that the facility failed to provide pressure ulcer treatment, consistent with professional standards of practice, for one of two residents reviewed for pressure ulcers (Resident R106). Findings Include: Review of facility policy "Pressure Ulcer Prevention" dated July 1, 2024, revealed "to prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure injury present." Review of Resident R106 's clinical record revealed that Resident R106 was admitted to the facility on January 30, 2025. Resident R106 has right heel Stage 3 (ulcer involving full thickness of skin loss).	F 0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0686 SS=D	Continued from page 37 Review of Resident R106's comprehensive care plan revised on February 4, 2025, revealed Resident R106 has impaired tissues integrity with a right heel wound and interventions included to offload heel when in bed and heel protectors while in bed to offload. Observation on April 25, 2025, at 11:25 a.m. of Resident R106 revelaed that the resident was in bed sleeping, there was no heel boot on the resident's right foot and the right heel was not offload. Interview with Nurse aide, Employee E22 on April 25, 2025, at 11:10 a.m. reported that resident had a boot in his closet and the boot was only applied at nighttime. Nurse aide, Employee E22 confirmed that the right heel was not offload when Resident R106 was observed in bed. Interview with the Nurse unit manager, Employee E3 on April 25, 2025, at 11:15 a.m. confirmed that Resident R106 rigth heel was not offloaded.	F 0686		

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F 0686 SS=D	Continued from page 38 28 Pa. Code 211.12 (d)(5) Nursing services 28 Pa. Code 211.10(c)(d) Resident care policies	F 0686		
F 0692 SS=D	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 0692	A – Resident R82 is receiving prosource and house supplement shakes with nursing documentation of percent consumed as nutritional interventions to assist with wound healing. B – All residents at nutritional risk with wounds audited to ensure nutritional interventions are in place. C – Educated dietitian on nutritional interventions for at risk residents and nutritional assessments D – weekly x 4 then monthly x 2 audit by DON or designee of newly at risk residents for nutritional interventions in place. Results discussed during QAPI meetings.	Completion Date: **06/23/2025** Status: **APPROVED** Date: **05/22/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0692 SS=D	Continued from page 39	F 0692		

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F 0692 SS=D	Continued from page 40 Based on clinical record review, interviews with staff and policy and procedure review, it was determined that the facility failed to implement nutritional interventions for one of three residents at nutritional risk related to pressure sore development and deteriation of wounds. (Resident R82) Findings include: A review of the policy titled nutritional management dated September 1, 2025 revealed that it was the responsibility of the facility to provide care and services to ensure that each resident maintained acceptable parameters of nutritional status related to his/her medical condition. The policy also indicated that the facility was responsible for revising ntritional interventions based on identification and routine assessment of resident's care needs. A review of the undated policy titled weight assessment and intervention revealed that it was the multidisciplinary teams' responsibility to prevent monitor and intervene for unplanned weight loss for	F 0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0692 SS=D	Continued from page 41 the residents. The policy indicated that weekly weights would be obtained at the discretion of the interdisciplinary team. The policy indicated that the physician and dietitian would be notified of unplanned changes in weight. The policy indicated that the dietitian was responsible for making recommendations to the physician for the management of the weight change. Care planning for weight loss or impaired nutrition would identify the root cause of the weight loss. A review of the undated policy titled charting and documentation revealed that all care planning and changes to the medical, physical, functional or psychosocial condition of the resident shall be documented in the medical record. The facility staff were responsible for documention all care specific details for each resident including: treatment provided and date, assessment data, unusual findings, intolerances, and notification of the physician and the family as needed.	F 0692		

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F 0692 SS=D	Continued from page 42 Clinical record review revealed a quarterly comprehensive assessment dated February 24, 2025 for Resident R82 that indicated this resident was cognitively impaired. The assessment indicated that Resident R82 had diagnoses that included: dementia, anemia, malnutrition and swallowing disorder. The assessment also indicated that this resident was seventy-four inches in height and was ordered a mechanically altered diet. The assessment said that Resident R82 was at high risk for pressure ulcer development and this resident had unhealed unstageable pressure ulcers. Clinical record review revealed a wound specialist progress note dated March 10, 2025. The progress note indicated that Resident R82 was evaluated with a scrotal surgical wound, left plantar foot deep tissue injury, and a newly identified sacral maceration and right ischial deep tissue injury. Interview with the wound specialist, Employee E17, at 1:30 p.m., on March 23, 2025 confirmed the status of the alterations in skin intergrity for Resident R82.	F 0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0692 SS=D	Continued from page 43 Clinical record review revealed a dietitian assessment dated March 19, 2025 that indicated Resident R82 was prescribed the 8 ounces of the house supplement (ensure plus or two calorie HN) once a day, to promote weight gain and skin healing. The nursing staff were responsible for the administration of the house supplement (Ensure plus or two calorie HN) once a day, to promote weight gain and skin healing. Clinical record review revealed on February 1, 2025 Resident R82 weighed 172 pounds. On March 25, 2025 Resident R82 weighed 162 pounds. This was a significant 5 % weight loss over one month. Resident R82's usual body weight was recorded at 170 pounds. Resident R82's ideal body weight was recorded at 190 pounds +/- 10%. There was no documentation to indicate that the nursing staff notified the dietitian of the significant weekly weight loss from March 19, 2025 (a weight was recorded at 165 pounds for resident R82) through March 25, 2025 (a weight was recorded at	F 0692		

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F 0692 SS=D	Continued from page 44 162 pounds). There was also no documentation to reflect that a nutritional assessment had been completed for Resident R82 on or after March 25, 2025. Clinical record review revealed a wound specialist progress note dated April 14, 2025 that indicated Resident R82 was being evaluated for the sacral wound that had evolved to a Stage III (ulcer involving full thickness of skin loss) pressure ulcer and a stage III pressure ulcer of the right ischial area. The physician indicated that Resident R82 was at risk for wound development and deterioration of skin with diagnoses of poor nutritional status and protein calorie malnutrition. Interview with the wound care specialist, Employee E17, at 1:30 p.m., on April 23, 2025 confirmed the progression of the skin brealdown for Resident R82. Clinical record documentation review revealed that the nursing staff were not administering the house supplement as care planned by the dietitian during the months of March and April, 2025.	F 0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0692 SS=D	Continued from page 45 Interview with the dietitian, Employee E16, at 1:00 p.m., on April 24, 2025 confirmed that the house supplement was not being administered during March or April, 2025 as care planned to meet the nutritional needs of Resident R82. During the interview with the dietitian, it was also confirmed that diagnostic data related to nutritional assessment and care planning was not available for review during the month of April, 2025. 28 Pa. Code 211.10(a)(b)(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 PA. Code 211.5(f)((i)(ii)(iii)(iv)(vii)(viii)(ix)(x)	F 0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0692 SS=D	Continued from page 46 Medical records	F 0692		
F 0695 SS=D		F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0695 SS=D	Continued from page 47 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	A – Resident R1suction machine obtained at the time identified . E20 was educated at the time this was reported. R51 oxygen tank was exchanged for a new tank at the time noted empty. E19 educated on ensuring 02 tanks are full when a resident is taken to the dining room. R10 obtained physician order to change tubing and tubing was changed. R72 oxygen tubing was changed at the time identified. B – Audit of all residents who require suctioning to ensure they have a suction machine at bedside and audit of all who require oxygen to ensure they have orders to change tubing weekly C – All nursing staff educated on weekly oxygen tubing change orders, ensuring suction machine a present at bedside for residents requiring suctioning, and ensuring oxygen tanks are not empty when in use by resident in dining room D – weekly x 4 then monthly x 2	Completion Date: **06/23/2025** Status: **APPROVED** Date: **05/23/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0695 SS=D	Continued from page 48	F 0695	audits by DON or designee to ensure oxygen tubing has weekly change orders and is changed weekly, residents in dining room who use oxygen do not have empty tanks, and a suction machine is present at bedside for those who require suction	

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F 0695 SS=D	Continued from page 49 Based on observation, clinical record review, review of facility policy and staff interview, it was determined that the facility failed to provide appropriate respiratory, tracheostomy and tracheal suctioning care and services for four of 23 residents reviewed (Resident R1, R10, R72, R51). Findings include: Review of the Facility Policy titled " Oxygen Administration" last revised July 1, 2024, indicated that " The purpose of this procedure is to provide guidelines for safe oxygen administration". It further stated under Preparation "verify that there is a physician's order". Review of Resident R10's clinical record revealed that the resident was initially admitted to the facility on August 11, 2015; diagnosed with emphysema (chronic lung condition), and dyspnea (shortness of breath). Review of clinical record indicated that Resident	F 0695		

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	395791	A. BLDG: __00_____ B. WING: _____	04/25/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
COMPLETE CARE AT HARSTON HALL LLC STATE LICENSE NUMBER: 080702	350 HAWS LANE FLOURTOWN, PA 19031

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F 0695 SS=D	Continued from page 50 R10 was ordered, dated March 25, 2025, oxygen at 2 Liters/Min, via nasal cannula, as needed for diagnosis of dyspnea. On April 22, 2025, at 12:22 p.m. an observation with Registered nurse, Employee E5 confirmed that Resident's R10 oxygen level was at 5-liter, oxygen tubing was not labeled. Employee E5 reported that her oxygen level was changed yesterday, and she did not change the order in the clinical record. It was further confirmed there was no order to change the oxygen tubing on weekly bases. Review of Resident R72's clinical record revealed that the resident was initially admitted to the facility on January 10, 2024; diagnosed with acute respiratory failure with hypoxia, chronic obstructive pulmonary disease. Review of clinical record indicated that Resident R72 was ordered, dated April 8, 2025, oxygen tubing changed weekly, label each component with date and initials, every shift every Sunday label each	F 0695		

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F 0695 SS=D	Continued from page 51 component with date and initials. On April 22, 2025, at 12:24 p.m. observation with Registered nurse, Employee E5 confirmed that Resident's R72 tubing was not labeled with date or initials. Review of facility policy "Tracheostomy Care", implemented on September 1, 2024, revealed Tracheostomy care will be provided according to the physician's orders, comprehensive assessment and individualized care plan such as monitoring for resident specific risks for possible complications, psychosocial needs as well as suctioning as appropriate. General considerations include: a. provide tracheotomy care at least twice a day, b. maintain a suction machine, a supply of suction catheters, correctly sized cannulas and an Ambu bag easily accessible for immediate emergency care. Review of facility policy "Tracheostomy Care-Suctioning", implemented on September 1, 2024, revealed the facility will ensure that residents who	F 0695		

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F 0695 SS=D	Continued from page 52 need respiratory care, including tracheal suctioning, are provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences. Tracheal suctioning is performed by a licensed nurse to clear the throat and upper respiratory tract of secretions that may block airway. Review of Resident R1 s clinical record revealed that Resident R1 was admitted to the facility with diagnoses of, but not limited to, Acute Respiratory Failure, Pneumonia, COPD (Chronic Obstructive Pulmonary Disease), Tracheostomy (allows air to pass into windpipe to help with breathing). Review of Resident R1's MDS (Minimum Data Set) on April 25, 2025 revealed that resident has a BIMS (Brief interview for mental status) of 7, indicating resident was not cognitively intact. Review of Resident R1's comprehensive care plan on April 25, 2025 revealed that resident has a	F 0695		

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F 0695 SS=D	Continued from page 53 tracheostomy related to impaired breathing mechanics. Intervention includes to suction the resident as needed. Review of Resident R1's clinical record revealed a physician order date April 9, 2025 to change disposable inner cannula. Further review of the clinical record revealed a physician order dated March 14, 2025 for Trach Care every day and night shift and Trach/ oral suction every day and night shift. Observation of Trach Care for Resident R1 on April 25, 2025 at 9:30 a.m. revealed that suctioning equipment was not at bedside. During trach care, Resident R1 was observed to be coughing and de-sating after inner cannula was replace. Licensed Nurse, Employee E20 left resident's bedside to retrieve suction cannula and tubing from medication room. Interview with Director of Nursing, Employee E2 on April 25, 2025 at 11:00 a.m. confirmed suction	F 0695		

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F 0695 SS=D	Continued from page 54 supplies should be at bedside at all times for a resident with a tracheostomy. Clinical record review for Resident R51 revealed a quarterly comprehensive assessment dated February 21, 2025 that indicated that this resident was cognitively impaired. The assessment also indicated that this resident had pulmonary diagnoses of respiratory failure and chronic obstructive pulmonary disease. Clinical record review revealed that Resident R51 was hospitalized on November 10, 2024 for sygns and symptoms of shortness of breath. The nursing staff noted that the resident's pulse oximeter reading was 80-88%, before transfer to the emergency medical team. Clinical record review for Resident R51 revealed a physician's order dated April 8, 2025 for the use of oxygen therapy. The physician order indicated that the nursing staff were to administered oxygen at 2 liters per minute via nasal cannula continuously The	F 0695		

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F 0695 SS=D	Continued from page 55 physician also gave orders for the licensed nursing staff to monitor pulse oximeter readings every day shift. Resident R51 was observed at 10:30 a.m., on April 25, 2025 seated in the wheel chair in the dining room, with no staff members in attendance. The resident was observed with an empty oxygen tank attached to the wheel chair and the tubing placed inside the resident's nostrils. The licensed practical nurse, Employee E19, confirmed that the resident was placed in the dining room without adequate oxygen therapy. 28 Pa Code 211.12(d)(5) Nursing services	F 0695		
F 0697 SS=D		F 0697		

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F 0697 SS=D	Continued from page 56 483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0697	A – Resident R48 plan of care and point of care were updated at the time noted to ensure turn and reposition avoids the right side. B – Audit of all residents with turn and reposition programs to ensure resident has no pain with turning with care plan updated as appropriate. C – All nursing staff educated to monitor for signs of pain with repositioning resident and avoid positions that cause pain to the resident. D – Weekly x 4 then monthly x 2 audits by DON or designee of residents with positional pain for pain management. Results discussed during QAPI meetings.	Completion Date: **06/23/2025** Status: **APPROVED** Date: **05/30/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0697 SS=D	Continued from page 57 Based on review of facility policy, review of clinical records and interviews with residents and staff, it was determined that the facility did not ensure proper pain management interventions were provided for one of 23 residents reviewed (Resident R48). Findings include: Review of facility policy "Pain Management", last reviewed on March 6, 2025, revealed the facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Review of Resident R48's clinical record revealed that Resident R48 was admitted to the facility on November 10, 2019 with diagnoses of, but not limited to, COPD (Chronic obstructive pulmonary disease), contracture of left knee, osteoarthritis of right shoulder.	F 0697		

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F 0697 SS=D	Continued from page 58 Review of Resident R48's comprehensive care plan on April 22, 2025 revealed that resident exhibited or was at risk for alterations in functional mobility related to contracture deformity. There was no documented evidence of care plan for pain management. Review of Resident R48's quarterly MDS (Minimum Data Set) dated February 28, 2025, revealed that resident has a BIMS (Brief interview for mental status) of 12, indicating resident is cognitively intact. Interview with Resident R48 on April 22, 2025 at 10:45am revealed that ResidentR48 had a lot of pain when rolled to his right side and reported telling multiple staff members "every time they change me" not to turn to right side however they do not listen and do it anyway and it causes a great deal of pain and discomfort." Interview with Clinical Regional Nurse, Employee	F 0697		

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F 0697 SS=D	Continued from page 59 E13, on April 23, 2025 at 10:00am revealed that resident expresses pain related contracture on right side and pain is increased when rolled to that side. Confirmed no care plan in place to prevent rolling the resident on his right side. Review of Resident R48 s clinical record on April 23, 2025, revealed a task for resident to be rolled Left and Right every 2-3 hours. Interview with Clinical Regional Nurse, Employee E13, on April 23, 2025 at 10:00 am confirmed task in place to roll resident to right and left side. 28 Pa Code 211.10(c) Resident care policies 28 Pa Code 211.12(d)(1) Nursing services	F 0697		
F 0725 SS=E		F 0725		

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F 0725 SS=E	Continued from page 60 483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F 0725	A – N/A B – Staffing Coordinator will staff the daily nursing staff to meet the required CNA to resident ratio of 1:10 on 7-3, 1:11 on 3-11, and 1:15 on 11-7. C – NHA, DON, and Staffing Coordinator educated on minimum staff to resident ratio. D – Weekly x4 then monthly x2 random audits by DON or designee of Cna staff ratio on 50% of days to ensure compliance with ratios	Completion Date: **06/23/2025** Status: **APPROVED** Date: **05/30/2025**

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F 0725 SS=E	Continued from page 61 Based on observations and staff interview, it was determined that the facility failed to address the care needs of a resident when answering call bells for one of 23 residents reviewed (Resident R29), and did not ensure sufficient staffing was maintained on a daily basis for all nursing units. (2nd and 3rd floors) Findings include: During a resident council meeting on April 24, 2025, at 10:00 a.m. with six residents, (Residents R37, R36, R81, R84, R89, and R31) who were identified as being alert and oriented, reported that call bells were not answered in a timely manner and staff were coming in and turn off the call bells without providing assistance. On April 24, 2025, at 11:07 a.m., an observation was made of Resident R29 lying flat in bed. The resident, who is non-verbal and communicates using head nods and facial expressions, clearly indicated a desire to be transferred into her wheelchair. The	F 0725		

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F 0725 SS=E	Continued from page 62 surveyor recommended the use of the call bell, and Resident R29 pressed it at 11:08 a.m. On April 24, 2025, at 11:11 a.m., Licensed Nurse, Employee E6 responded to the call. Upon entering the room, Licensed Nurse, Employee E6 asked the resident what she needed. Resident R29 pointed to her wheelchair, indicating she wanted to be transferred. Licensed Nurse, Employee E6 informed her that she had been changed and that her assigned nurse aide would be in to assist with the transferring the resident out of bed. Licensed Nurse, Employee E6 then turned off the call bell and exited the room. On April 24, 2025, at 11:22 a.m., the surveyor observed Nurse aide, Employee E24 walking through the hallway and asked whether she had been notified of Resident R29's need for a transfer. Nurse aide, Employee E24 reported that she had not been informed and stated her role was to provide transport and respond to call bells. Interview with Nurse aide, Employee E25, who was	F 0725		

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F 0725 SS=E	Continued from page 63 also present in the hallway near the room where Resident R29 lived stated that she had not been informed of the resident's need and that Resident R29 was not part of her caseload. The surveyor proceeded to the nursing station, where approximately four staff members were seen conversing. Licensed Nurse E6 was observed working at the computer. Employee E6 explained that the nurse aid assigned to Resident R29 was occupied with cleaning another room and stated, "she's unable to do everything." Shortly thereafter, Employee E25 volunteered to assist and called upon Employee E24 to help. Resident R29 was transferred to her wheelchair at 11:26 a.m. Since the call bell was turned off by Employee E6 and there was no further indication that Resident R29 needed help. On April 24, 2025, at 2:55 p.m. an interview was conducted with the Administrator, Employee E1 who confirmed that staff members should not be	F 0725		

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F 0725 SS=E	Continued from page 64 turning off the call bells without ensuring that the resident's needs are addressed. Review of nursing care staffing levels revealed that the facility failed to meet the state required minimum number of 3.2 care hours per patient per day (PPD) on five of 21 days reviewed (February 9, 14 and 15, 2025, and April 20 and 22, 2025), and did not meet the state required minimum Nurse Aide staffing ratios on 13 of 21 days reviewed (February 9-15, 2025, and April 18-20, and 22-24, 2025). In an interview with the staffing coordinator, employee E33, on April 24, 2025, at 2:30 p.m., she confirmed that the staffing levels did not meet state minimum requirements and stated that the facility was "always understaffed". 28 Pa Code 211.12(d)(4) Nursing services 28 Pa Code 211.12(f.1)(3)(4) Nursing services 28 Pa Code 211.12(i)(2) Nursing services	F 0725		

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F 0725 SS=E	Continued from page 65 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(a)(3) management	F 0725		
F 0726 SS=D	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to	F 0726	A – Resident R1 suction supplies obtained and placed at bedside. Employee E2 was competence after the event was reported. B – N/A C – All nursing staff completed competencies on suctioning of resident with tracheostomy prior to next shift worked. New Jersey Respiratory Association completed additional in-services with staff. D – weekly x 4 then monthly x 2 audits by DON or designee of new staff to ensure trach care training and competency is completed. Results discussed during QAPI meetings.	Completion Date: **06/23/2025** Status: **APPROVED** Date: **05/30/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395791	A. BLDG: __00_____ B. WING: _____	04/25/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
COMPLETE CARE AT HARSTON HALL LLC STATE LICENSE NUMBER: **080702**	**350 HAWS LANE** **FLOURTOWN, PA 19031**

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F 0726 SS=D	Continued from page 66 demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by:	F 0726		

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F 0726 SS=D	Continued from page 67 Based on obervations, review of facility policy, review of employee personnel files and interviews with staff, it was determined that the facility did not ensure staff was qualified and competent to perform tracheostomy care and suctioning care for one of one resident reviewed (Resident R1). Findings Include: Review of facility policy "Orientation", implemented on September 1, 2024, revealed it is the policy of this facility to develop, implement and maintain an effective orientation process for all new staff, individuals providing services under a contractual arrangement and volunteers, consistent with their expected roles. Further review of section "Policy Explanation and Compliance Guidelines" part 6., Competency evaluation form process: section e., the completed form represents initial competency in skills needed to care for residents and perform job functions. Review of facility policy "Tracheostomy Care-	F 0726		

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F 0726 SS=D	Continued from page 68 Suctioning", implemented on September 1, 2024, revealed the facility will ensure that residents who need respiratory care, including tracheal suctioning, are provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences. Tracheal suctioning is performed by a licensed nurse to clear the throat and upper respiratory tract of secretions that may block airway. Review of Resident R1's clinical record revealed that Resident R1 was admitted to the facility with diagnoses of, but not limited to, Acute Respiratory Failure, Pneumonia (an infection of the aire sacs), COPD (Chronic Obstructive Pulmonary Disease), and Tracheostomy (allows air to pass into windpipe to help with breathing). Review of Resident R1's clinical record revealed a physician order date April 9, 2025 to change disposable inner cannula. Further review of the clinical record revealed a physician order dated	F 0726		

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F 0726 SS=D	Continued from page 69 March 14, 2025 for Trach Care every day and night shift and Trach/oral suction every day and night shift. Observation of Trach Care for Resident R1 on April 25, 2025 at 9:30 a.m. revealed that suctioning equipment was not at bedside. During trach care, Resident R1 was observed to be coughing and de-sating after inner cannula was replace. Licensed Practical Nurse, Employee E20 left resident's bedside to retrieve suction cannula and tubing from medication room. Interview with Director of Nursing, Employee E2 on April 25, 2025 at 11:00 a.m. confirmed suction supplies should be at bedside at all times for a resident with a tracheostomy. Interview with Licensed Practical Nurse, Employee E20 on April 25, 2025 at 11:30am revealed staff receives no training or in-service from facility to confirm competency in Tracheostomy Care or Suctioning.	F 0726		

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F 0726 SS=D	Continued from page 70 Interview with Directory of Nursing, Employee E2 on April 25, 2025 at 12:30pm confirmed no documented evidence of Tracheostomy Care or suctioning competencies for Licensed Practical Nurse, Employee E20. Further Review of Facility's employee personnel files on April 25, 2025 at 12:30 p.m revealed no documented evidence of Tracheostomy Care or suctioning competencies completed by any licensed nursing staff in facility. Interview with Director of Nursing, Employee E2 on April 25, 2025 at 1:00pm confirmed no documented evidence of completed Tracheostomy care or suctioning competencies for any licnesed nursing staff in facility. 28 Pa Code 201.19(6)(7) Personnel policies and procedures 28 Pa Code 201.20(b)(d) Staff development 28 Pa. Code 211.12(d)(1) Nursing services	F 0726		

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F 0726 SS=D	Continued from page 71	F 0726		
F 0730 SS=E	483.35(d)(7) Nurse Aide Peform Review-12 hr/yr In-Service §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:	F 0730	A – Facility contracted with Healthcare Academy platform to provide required trainings for staff. B – Audit completed on all facility CNAs to evaluate hours of training received in past year or since hire date. C – All CNAs educated on requirement of 12 hours of annual training and the use of Healthcare Academy. D – Weekly x 4 then monthly x 2 audits by DON or designee to ensure CNAs meet the required 12 hours of annual education. Results discussed during QAPI meetings.	Completion Date: **06/23/2025** Status: **APPROVED** Date: **05/30/2025**

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F 0730 SS=E	Continued from page 72 Based on review of facility provided documentation and interview with staff, it was determined that facility did not ensure annual performance evaluation was completed for three nurse aides out of three nurse aides' trainings reviewed (Employee E21, E22 and E23) Findings include: Review of facility policy titled Required Training Certification and Continuing Education on Nurse Aides, revised in 2024, indicates that "the facility will provide at least 12 hours of in-service training annually, based on the employment date, not calendar year." Review of facility provided performance evaluations on Thursday, April 25, 2025, revealed that nurse aides, Employees E21, E22 and E23 did not have any 12 hours of in-service training. Interview with Development Coordinator on April 25, 2025, at 1:40 p.m, confirmed that there was no	F 0730		

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F 0730 SS=E	Continued from page 73 12 hours of in-service training annually. 28 Pa Code 201.19(2) Personnel policies and procedures	F 0730		
F 0755 SS=D	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ	F 0755	A – N/A B – Narcotic reconciliation records audited for missing signatures. C – All nurses educated on Narcotic count and reconciliation process D – Weekly x 4 then monthly x 2 audits by DON or designee of narcotic counts and reconciliation to ensure completion. Results discussed during QAPI meetings.	Completion Date: **06/23/2025** Status: **APPROVED** Date: **05/30/2025**

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F 0755 SS=D	Continued from page 74 or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by:	F 0755		

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F 0755 SS=D	Continued from page 75 Based on review of facility records and staff interviews, it was determined that facility did not ensure that the narcotic reconciliation record was complete related to missing signatures and initials on the narcotic count sheet for three of three medication carts reviewed. (2nd Floor Medication Cart, and two medication carts on 3rd Floor) Findings include: Review of Facility In-service "Shift to Shift count", implemented in October 2024, revealed nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. Observation of Medication Cart on 2nd Floor on April 24, 2025 at 2:20 p.m., revealed multiple missing signatures during the month of April 2025 for oncoming and outgoing nurses on Narcotic Reconcilation Sheet. Licensed Practical Nurse, Employee E9. confirmed at the time of the observation that the narcotic reconcilation sheet was	F 0755		

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F 0755 SS=D	Continued from page 76 missing signatures from oncoming and outgoingt nurses confirming the narcotic count. Observation of Medication Cart on 3rd Floor on April 24, 2025 at 2:33 p.m., revealed multiple missing signatures during the month of April 2025 for oncoming and outgoing nurses on Narcotic Reconcilation Sheet. It was confirmed on April 24, 2025 at 2:33 p.m. by Licensed Practical Nurse, Employee E10. Observation of a second Medication Cart on 3rd Floor on April 24, 2025 at 2:45 p.m., revealed multiple missing signatures during the month of April 2025 for oncoming and outgoing nurses on Narcotic Reconcilation Sheet. It was confirmed on April 24, 2025 at 2:45pm by Licensed Practical Nurse, Employee E20. Interview with Clinical Regional Nurse, Employee E13 on April 25, 2025 at 10:00am, confirmed missing signatures and missing initials on the narcotic reconciliation sheets.	F 0755		

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F 0755 SS=D	Continued from page 77 28 Pa Code 211.9(a)(1) Pharmacy services 28 Pa Code 211.12(d)(5) Nursing services	F 0755		
F 0761 SS=D	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 0761	A – Medications identified at the time of survey that were not dated were removed from the med carts and replaced with new medications. B – Audit of med carts and all undated multidose containers of meds removed with new ones obtained. New meds dated when opened. C – All nurses educated on dating multidose medication containers when opened. D – Weekly x 4 then monthly x 2 audits by DON or designee of multidose med containers to ensure open containers are dated. Results discussed during QAPI meetings.	Completion Date: **06/23/2025** Status: **APPROVED** Date: **05/30/2025**

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F 0761 SS=D	Continued from page 78 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761		

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F 0761 SS=D	Continued from page 79 Based observations and staff interviews, it was determined that facility did not ensure that opened medications were properly labeled with the date that the medication was opened for two of three medication carts reviewed and one of one medication room reviewed. (2nd floor medication cart, 3rd floor medication cart and 2nd floor medication room). Findings include: Observation of Medication cart on 2nd floor on April 24, 2025 at 2:20 pm revealed 5 opened bottles of medication, including B12, Cranberry, Vitamin D, Ferrous Sulfate and B1, not labeled with an open date. Interview with Licensed nurse, Employee E9 on April 24, 2025 at 2:21pm confirmed 5 opened bottles of medication not labeled with an open date. Observation of Medication Cart on 3rd floor on April 24, 2025 at 2:33pm revealed 1 opened bottle	F 0761		

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F 0761 SS=D	Continued from page 80 of medication, including Vitamin D 1250mg, not labeled with an open date. Interview with Employee E10 on April 24, 2025 at 2:35 pm confirmed 1 open bottle of Vitamin D, no label with open date. Observation in 2nd Floor Med Room on April 24, 2025 at 2:25pm revealed open bottle of Tuberculin with no open date labeled. Interview with Employee E9 on April 24, 2025 at 2:26pm confirmed open bottle of Tuberculin with no open date labeled. 28 Pa. Code 211.12 (d)(1) Nursing services.	F 0761		
F 0804 SS=E		F 0804		

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F 0804 SS=E	Continued from page 81 483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by:	F 0804	A – The heated pellet warmer was assessed and not able to be repaired. A replacement warmer was ordered and expected to arrive on 05/27/25. The steam table and bistro steam table were assessed and service call placed for repair. B – Audit of new/repaired equipment to ensure proper function once installed/repaired. C – Dietary manager educated on checking for proper food temperatures prior to delivery to residents D – Weekly x 4 then monthly x 2 audits by dietary manager or designee to ensure foods are at proper temperature. Results discussed during QAPI meetings.	Completion Date: **06/23/2025** Status: **APPROVED** Date: **05/30/2025**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0804 SS=E	Continued from page 82 Based on observations of the food and nutrition services department, reviews of policies and procedures and interviews with staff and residents, it was determined that the facility failed to ensure that foods and drinks were being served palatable, attractive and at safe and appetizing temperatures during meal times for the residents. (Third floor, noon meal) Resident council (Residents R37, R36, R81, R84, R89, and R31) Findings include: A review of the facility's policy titled resident test tray assessment dated April, 2025 indicated that hot food entrees and vegetables were to be served at a temperature of 130 degrees Fahrenheit and all cold foods and beverages were to served at 45 degrees Fahrenheit. The temperatures were established to ensure safety and resident satisfaction at point of service, with the foods and fluids prepared by the food service department. On April 22, 2025, at 12:54 p.m., an interview was	F 0804		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395791	A. BLDG: __00_____ B. WING: _____	04/25/2025

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F 0804 SS=E	Continued from page 83 conducted with Resident R15, who stated that the food at the facility is "terrible." Observation of the resident's plate revealed that only a piece of bread, juice, and ice cream had been consumed from the lunch tray. Observations of the tray line assembly area in the main kitchen , where foods are prepared for delivery to the nursing unit revealed that cold food items (sandwiches: cheese, turkey and cheese and turkey salad platters) were not being held cold. The time and temperature sensative food items were placed on an open cart in the middle of the main kitchen and held throughout the meal trayline preparation for delivery to the nursing units. Interview with the director of dietary services, Employee E15 at 11:30 a.m., on April 23, 2025 revealed that since the food service equipment was broken (reach-in refrigerator unit); we have not been able to hold the prepared cold food items under refrigeration.	F 0804		

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F 0804 SS=E	Continued from page 84 Observations of the lowerator (heated pellet drop in dispenser unit) at 11:30 a.m., on April 23, 2025 revealed that this piece of food service epuipment was not fully functioning. One of the drop in dispenser units was not warm. The pellets were cool to touch. The other two dispensers were not hot; that was the pellets were lifted out of the dispensers with out using the handle that was designed for lifting hot pellets with ease. The internal temperature of the heated pellet drop in dispenser unit ranges from 250 to 290 degrees Fahrenheit when fully operational. Dietary staff were required to use gloves or a handle to lift the pellet and place it in the pellet holder on the residents' meal trays during tray line and assembly of foods and drinks. Observations of the steam table located in the main kitchen of the dietary services department revealed that it was not fully operational. The dietary staff had to have a large bucket to catch and contain the constant leaking of the water place inside the wells of the unit. The dietary cooks were documenting	F 0804		

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F 0804 SS=E	Continued from page 85 hot food holding temperatures of 145 degrees Fahrenheit for hot foods. Observations of the built in steam table located in the bistro part of the dietary services department on the first floor of the facility revealed that two of the four wells in that unit were not fully functioning. A test tray evaluation was completed on the Third floor nursing unit with the director of dietary service, Employee E15, during the noon meal service for the residents on April 23, 2025. Observations of the noon meal service on the third floor nursing unit revealed that hot food and cold fodd items were not being served to the residents at appetizing temperatures. A test tray was evaluation on the April 23, 2025 during the noon meal service on the third floor revaled a glazed ham glazed 3 ounces was planned on the menu however only a two ounce potion was given. The temperature of the glazed ham at point of service was 115 degrees Fahrenheit. The vegeatables planned on the menu were steamed	F 0804		

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F 0804 SS=E	Continued from page 86 cabbage and baked sweet potatoes. The temperature of the foods tested at 116 degrees Fahrenheit. The dessert planned on the menu was a cranberry crunch bar. The residents were served angel food cake with cranberry sauce. The angel food cake and cranberry sauce was slanted side ways and attempted to be portioned in a small bowl. The director of dietary services said that the dietary staff ran out of small cake plates. The drinks were coffee milk and fruit punch. The time temperature sensative milk was served at 60 to 67 degrees Fahrenheit. The foods and fluids served on April 23, 2025 were not appetizing, attractive, portion specific or at safe satisfying temperatures for the residents. The facility policy for point of service temperatures were have hot food served at 130 degrees Fahrenheit and cold foods to be served at 45 degrees Fahrenheit. During a resident council meeting on April 24, 2025, at 10 a.m. on the second floor with six residents, (Residents R37, R36, R81, R84, R89, and R31) who were identified as being alert and oriented,	F 0804		

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F 0804 SS=E	Continued from page 87 reported that food is served cold, uncooked meat, overcooked vegetables, fish served very smells and not getting night snacks. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management	F 0804		
F 0812 SS=F		F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0812 SS=F	Continued from page 88 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	A – The heated pellet warmer was assessed and not able to be repaired. A replacement warmer was ordered and expected to arrive on 05/27/25. The steam table and bistro steam table were assessed and service call placed for repair. B – Audit of new/repaired equipment to ensure proper function once installed/repaired. C – Dietary manager educated on checking for proper food temperatures prior to delivery to residents D – Weekly x 4 then monthly x 2 audits by dietary manager or designee to ensure foods are at proper temperature. Results discussed during QAPI meetings.	Completion Date: **06/23/2025** Status: **APPROVED** Date: **05/30/2025**

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F 0812 SS=F	Continued from page 89 Based on observations of the food and nutrition services department, it was determined that foods were not being stored, prepared, distributed and served in accordance with professional standards for food service safety. Findings include: Observations on March 22, 2025 of the main kitchen where foods and beverages were stored, prepared and assembled for distribution and service to the residents revealed that the low temperature dish machine was not fully functioning since March 14, 2025. The director of dietary service could not demonstrate with the use of litmus test strip that the hypochlorite was registering an acceptable 50 ppm (parts per million) to effectively sanitize the dishes, utencils, pots, pans, cups, bowls, plates and trays for resident and dietary staff use. Interview with the Director of Dietary Services, Employee E15 revealed that the main kitchen operation had been waiting on a customized part	F 0812		

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F 0812 SS=F	Continued from page 90 (squeeze tube and rinse assembly metal connector) for the mechanics of the dish machine, since March 14, 2025. All of the dome lids and plate holders contained a white film like substance, which the Director of Dietary Services reported was calcium and magnesium deposits from the hard water (water high in mineral content) usage. The Director of Dietary Services reported that there was no water softener in operation inside the food and nutrition services department. The flooring in the dish room area was water damaged and in need of repair. The grouting surrounding the floor drain and throughout the dish room was warn away leaving the grooves between the ceramic floor tiles with constant stagnant water and food debris. Ceramic floor tiles were missing and broken that were near the floor drain. The flooring in the dish room underneath the dish machine contained a build up of food debris, sludge and moist dirt.	F 0812		

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F 0812 SS=F	Continued from page 91 The basic white drop ceiling tiles above the dish machine area contained dried food debris that was splattered across the ceiling. The white drop ceiling tiles above the hot food cooking (gas stove, grill and oven) and preparation area contained a film of grease. The tiles were observed to be light yellow instead of white there original color. The wall area behind the dish machine across the lip of the flight type dish machine and its' attachment to the wall, contained a black substance resembling mold. Observations on March 22, 2025 of the alcove that was adjacent to the dish machine and ice machine revealed that there was piping in this area that was not funneled to the floor drain. A constant flowing of water was noted on the floor in this area along with a white green and black tinged film. The wall area where the pipe was attached was water damaged. The plaster board was damp and cracking.	F 0812		

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F 0812 SS=F	Continued from page 92 The walk-in refrigerator unit was heavily soiled. The walls and floors of this refrigerator contained a build-up of dirt, food spillage and white film-like substances. The air circulation fan screens were soiled with dust, dirt. The large metal food storage racks were soiled with sticky food pieces. The shelving was also soiled with dirt and rust. The lighting inside this walk-in refrigerator unit was dull; making the refrigerator not easily cleanable. The reach-in refrigerator and reach-in freezer units were not function. The Director of Dietary Services, Employee E15, reported that it has been for several months without the use of the reach-in refrigerator or freezer units. The preparation sink was leaking water onto the flooring while dietary staff were using it to prepare foods. The steam table was leaking water onto the flooring tray line assembly. Dietary staff were using bins to collect the water as it leaked from the sinks and steam table unit inside the main kitchen.	F 0812		

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F 0812 SS=F	Continued from page 93 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3)(e)(1)(2.1)(3) Management	F 0812		
F 0842 SS=D		F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0842 SS=D	Continued from page 94 483.20(f)(5), 483.70(h)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 0842	A – CNAs assigned to Resident R82 were educated on completing documentation for turning and repositioning. B – Audited all residents with turn and repositioning programs to ensure documentation is being completed C - All nursing staff educated on documentation requirements for turning and positioning in point of care. D – Weekly x 4 then monthly x 2 audits by DON or designee to ensure documentation of turning and repositioning in point of care is completed. Results discussed during QAPI meetings.	Completion Date: **06/23/2025** Status: **APPROVED** Date: **05/30/2025**

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F 0842 SS=D	Continued from page 95 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 0842		

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F 0842 SS=D	Continued from page 96 This REQUIREMENT is not met as evidenced by:	F 0842		

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F 0842 SS=D	Continued from page 97 Based on clinical records review, staff interview and review of facility policy, it was determined that the facility failed to ensure that clinical records wer completed for one of 23 clinical records reviewed. (Resident R82) Findings include: Review of facility policy "Turning and repositioning", implemented on September 1, 2024, revealed all residents at risk of, or with existing pressure injuries, will be turned and repositioned, unless it is contraindicated due to medical condition. The frequency of turning and repositioning will be documented in the resident's plan of care. Review of Resident R82 's clinical record revealed that Resident R82 was admitted to the facility on April 27, 2023 with diagnoses of, but not limited to, Dementia (progressive degenerative disease of the brain), Heart failure, Type 2 Diabetes (failure of the	F 0842		

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F 0842 SS=D	Continued from page 98 body to produce insulin) and Acute Kidney failure. Review of Resident R82' s MDS (Minimum Data Set- resident assessment of care needs) revealed that resident had a BIMS (Brief interview for mental status) of 6, indicating resident was not cognitively intact. Review of Resident R82's clinical record revealed Resident R82 has a Stage III (ulcer involving full thickness of skin loss) pressure ulcer on right buttocks that initially presented on March 10, 2025 as a DTI (deep tissue injury) and a Stage III pressure ulcer on sacrum that initially presented on March 3, 2025 as a MASD (Moisture associated skin damage). Interview with Rehab Director, Employee E11 on April 23, 2025 at 1:45 pm revealed that Resident R82 needed to be prompted to be repositioned, otherwise the resident would not be able to do it himself.	F 0842		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
COMPLETE CARE AT HARSTON HALL LLC STATE LICENSE NUMBER: **080702**	**350 HAWS LANE** **FLOURTOWN, PA 19031**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0842 SS=D	Continued from page 99 Review of Resident R82 s clinical record revealed task in place for resident to be turned and reposition every 2-3 hours side to side while in bed. No documented evidence that task was completed. Interview with the Director of Nursing, Employee E2 on April 23, 2025 at 2:00pm confirmed no documented evidence of task to turn and reposition resident every 2- 3 hours side to side while in bed was completed. 28 Pa. Code 211.12(d)(1) Nursing services	F 0842		
F 0880 SS=E		F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395791	A. BLDG: 00 B. WING:	04/25/2025

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F 0880 SS=E	Continued from page 100 483.80(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	A - At the time reported, bed linens in the laundry room and pillows and additional lift pads in the 2nd floor linen room that were stored on the floor were removed and laundered. Proper equipment to store linen was added in the areas to prevent it from touching the floor. B - Audit conducted to ensure any other areas that store linen did not have linen stored directly on the floor. C - Laundry and nursing staff educated on proper linen storage which is not to store items even if bagged on the floor. D – Weekly x 4 then monthly x 2 audits by Environmental services director or designee of linen storage areas to ensure linens are not stored on the floor. Results discussed during QAPI meetings.	Completion Date: **06/23/2025** Status: **APPROVED** Date: **05/30/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0880 SS=E	Continued from page 101 (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		

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F 0880 SS=E	Continued from page 102	F 0880		

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F 0880 SS=E	Continued from page 103 Based on a review of facility policies, observations, and staff interviews, it was determined that the facility failed to store bed linens in a sanitary environment, increasing the risk of infection and contamination. (Laundry room) Findings: A review of the policy titled 'Laundry Services" revised July 1, 2024, it revealed " the facility lauders and delivers linens and clothing in accordance with current CDC guidelines to prevent transmission of pathogens". On April 22, 2025, at 1:23 p.m., a tour of the laundry area located in the basement was conducted with the housekeeping supervisor, Employee E4, where laundry operations occur. During the tour, it was observed and confirmed that new linens were unfolded and placed directly on the bare floor inside the extra linen closet. These linens were neither boxed nor covered, leaving them exposed to potential contamination.	F 0880		

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F 0880 SS=E	Continued from page 104 Additionally, an inspection of the second-floor linen closet revealed that clean pillows, although sealed in plastic bags, were stored directly on the floor. Extra pads use for a mechanic lifts, were not sealed or protected, were also found stored on the floor. 28 Pa. Code 201.18(b)(3) Mangement	F 0880		
F 0908 SS=D		F 0908		

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F 0908 SS=D	Continued from page 105 483.90(d)(2) Essential Equipment, Safe Operating Condition §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by:	F 0908	A – The heated pellet warmer was inspected and unable to be repaired. A replacement warmer was ordered and expected on 5/27/25. The Steam table and bistro steam table had service calls placed for repair or replacement. The squeeze tube and rinse assembly metal connector was replaced and functioning now. B – N/A C – The dietary manager and dietary staff educated on safe food handling temperatures of cold and hot foods. D – weekly x 4 then monthly x 2 audits by dietary manager to ensure pellet warmer and steam tables are functioning and to ensure foods are handled at proper temperatures (hot or cold). Results discussed at QAPI meetings.	Completion Date: **06/23/2025** Status: **APPROVED** Date: **05/30/2025**

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F 0908 SS=D	Continued from page 106 Based on observations and interviews with dietary and administrative staff, it was determined that essential food service equipment was not maintained in safe operating condition. Findings include: Observations on March 22, 2025 of the main kitchen where foods and beverages were stored, prepared and assembled for distribution and service to the residents revealed several pieces of equipment that were not fully functioning. Observations of the dish machine revealed that it was not being maintained according to manufacturer's recommendations. The low temperature dish machine was not fully functioning since March 14, 2025. The director of dietary service could not demonstrate with the use of litmus test strip that the hypochlorite was registering an acceptable 50 ppm (parts per million) to effectively sanitize the dishes, utencils, pots, pans, cups, bowls,	F 0908		

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F 0908 SS=D	Continued from page 107 plates and trays for resident and dietary staff use. Interview with the director of dietary services, Employee E15 revealed that the main kitchen food service operation had been waiting on a customized part (squeeze tube and rinse assembly metal connector) to effectively and safely operate the dish machine, since March 14, 2025. Observations of the tray line assembly area in the main kitchen on April 22 and April 23, 2025, where foods are prepared for delivery to the nursing units, revealed that cold food items (sandwiches: cheese, turkey and cheese and turkey salad platters) were not being held cold. These time and temperature sensitive food items were placed on an open cart in the middle of the main kitchen and held throughout the meal trayline preparation and then delivery to the nursing units. Interview with the director of dietary services, Employee E15 at 11:30 a.m., on April 23, 2025 revealed that since the food service equipment was	F 0908		

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F 0908 SS=D	Continued from page 108 broken (reach-in refrigerator unit and reach-in freezer unit); dietary staff have not been able to hold the prepared cold food items under refrigeration on the assembly line or quick chill in the freezer on the assembly line. Observations of the lowerator (heated pellet drop in dispenser unit) at 11:30 a.m., on April 23, 2025 revealed that this piece of food service epuipment was not fully functioning. One of the drop in dispenser units was not warm. The pellets were cool to touch. Dietary staff were lifting the pellets without hand protection. The other two dispensers were not hot; meaning the pellets were lifted out of the dispensers with out using the handle that was designed for lifting hot pellets with ease. The internal temperature of the heated pellet drop in dispenser unit ranges from 250 to 290 degrees Fahrenheit when fully operational. Dietary staff were required according to manufacturer's recommendations to use gloves or a handle to lift the pellet and place it in the pellet holder on the residents' meal trays during tray line and assembly of	F 0908		

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F 0908 SS=D	Continued from page 109 foods and drinks. Observations on April 22, 2025 of the steam table located in the main kitchen of the dietary services department revealed that it was not fully operational. The dietary staff had to have a large bucket to catch and contain the constant leaking of the water from the steam table well. According to manufacturer's recommendations water added to the the wells of the unit. The dietary cooks documented hot food holding temperatures of 145 degrees Fahrenheit for foods. Observations on April 23, 2025 of the built in steam table unit located in the bistro on the first floor of the building revealed that two of the four wells in that unit were not fully functioning. The bistro was part of the dietary services that were operated by the food and nutrition services department. Interview with the administrator, Employee E1, at 11:00 a.m., on April 24, 2025 confirmed the lack maintenance to ensure that essential food service	F 0908		

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F 0908 SS=D	Continued from page 110 equipment (dish machine, lowerator, reach-in refrigerator, reach-in freezer unit and steam tables) was in safe mechanical and electrical condition to operate the food and nutrition services department. 28 PA. Code 201.14(a) Responsibility of licensee 28 PA. Code 201.18(b)(3) Management	F 0908		
F 0925 SS=D		F 0925		

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F 0925 SS=D	Continued from page 111 483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by:	F 0925	A – The flooring directly underneath the dish machine was scrubbed and cleaned. Floor in dish machine area was cleaned and repaired with new tiles. The adjacent alcove was repaired and free from any holes and wall board fastened. Pipe fixed and realigned to floor drain. B – Preparation sink in the main kitchen being repaired by outside plumbing vendor. C – All state educated on pest control interventions and utilization of the pest control binders to report concerns to the pest control service technician. D – Weekly x 4 then monthly x 2 audits by maintenance director of pest control binders to ensure concerns are addressed and audits of the kitchen floor for maintenance concerns. Results discussed in QAPI meetings.	Completion Date: **06/23/2025** Status: **APPROVED** Date: **05/30/2025**

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F 0925 SS=D	Continued from page 112 Based on observations, resident and staff interviews, review of the pest control logs and the pest control operator's management program, review of policies and documentation, it was determined that the facility failed to maintain an effective pest control program in the kitchen and one of two nursing units. (3rd Floor Nursing Unit and Kitchen) Findings include: A review of facility "Pest Control" policy revised July 1, 2024, states that "It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pest and rodents". On April 22, 2025, at 12:00 p.m., an observation conducted with Licensed Nurse Employee E12 confirmed that Resident R24 had gnat flies in his room. Employee E12 further stated that "always had gnat flies' issues". On April 24, 2025, at 9:45 a.m., an interview was	F 0925		

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F 0925 SS=D	Continued from page 113 conducted with the Maintenance Director, Employee E8, who reported that the facility receives pest control treatments on a weekly basis. However, a review of pest control invoices for the past three months revealed that treatments were actually conducted twice a month. Invoices reviewed included service dates of January 10 and 29, 2025; February 7 and 21, 2025; March 7 and 21, 2025; and April 4 and 18, 2025. There was no documentation supporting weekly pest control visits. A review of the facility's pest control logbooks from January 24, 2025- April 18, 2025, did not reveal any documentation for the gnat flies in room 307. Review of the pest control invoices from January 10, 2025, through April 18, 2025, there was no treatment conducted in room 307 for gnats. The only gnat activity documented was in the following reports of March 7 and 21, 2025. Review of pest invoice on March 7, 2025, revealed "Inspected and treated through lobby, nursing	F 0925		

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F 0925 SS=D	Continued from page 114 stations, kitchen, laundry room, employee break room, office personnel's physical therapy and lounges for general pest. Inspected and treated 2nd floor and 3rd floor staff restrooms for roach activity. Battled and placed monitors. Nursing staff on 3rd floor verbally reported heavy gnat activity in room 313. Recommend to utilized logbooks. No reports written in other logbooks. Review of the pest invoice on March 21, 2025, revealed " inspected and treated 3rd floor room 313 for gnat and fly activity. Spoke with Admin". Observations of the food and nutrition services department on April 22, 2025 revealed that the flooring directly underneath the dish machine was heavily soiled with food debris, dirt and sludge There were areas of pooling water and food debris in the gaps/grooves between the ceramic tiled flooring throughout the dish machine area. The floor in this area was surrounded by deep grooves from water damage. Many of the ceramic tiles were missing or broken. The adjacent alcove contained a	F 0925		

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F 0925 SS=D	Continued from page 115 wall area with holes and a dampened, loose wall board. This was noted with the constant dripping of water on to the floor. The piping dripping the water was not aligned with the floor drain. The lack of housekeeping and maintenance of the dish room provided places for pests and rodents to live and breed. The drop ceiling tiles above the dish machine contained dried food splatter across the front of the panels. The ceiling tiles above the hot food preparation area contained a film of cooking grease that was covering the panels. The lack of housekeeping provided food for pests to live and breed. The preparation sink in the main kitchen was leaking water onto the flooring while it was in use. The steam table in the main kitchen was leaking water onto the floor; unless dietary staff used a bin to capture the water. The lack of maintenance of equipment allowed easy access to food for pests and rodents.	F 0925		

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COMPLETE CARE AT HARSTON HALL LLC STATE LICENSE NUMBER: **080702**	**350 HAWS LANE FLOURTOWN, PA 19031**

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F 0925 SS=D	Continued from page 116 A review of the pest control operators reports for the months of January, February, March and April, 2025 revealed that the main kitchen was being treated for common household pests and rodents (roaches and mice). The consulting pest control operator documented active roach observations in January, 2025, for the main kitchen. The consulting pest control operator documented active mice observations in April, 2025, for the main kitchen. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(e)(1)(2.1) Management	F 0925		
F 0943 SS=D		F 0943		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395791	A. BLDG: 00 B. WING:	04/25/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
COMPLETE CARE AT HARSTON HALL LLC STATE LICENSE NUMBER: **080702**	**350 HAWS LANE** **FLOURTOWN, PA 19031**

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F 0943 SS=D	Continued from page 117 483.95(c)(1)-(3) Abuse, Neglect, and Exploitation Training §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by:	F 0943	A – Employee E29 received the appropriate abuse, neglect, and misappropriation training. B – Audit of all employees hired in 2025 education files to ensure the abuse, neglect, and misappropriation training has been completed. Completion of training for anyone not completed. C – Staff Development Coordinator and Human Resources Director educated on ensuring training is completed upon hire. D – weekly x4 then monthly x 2 audits by administrator or designee of new hires to ensure completion of required trainings.	Completion Date: **06/23/2025** Status: **APPROVED** Date: **05/30/2025**

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F 0943 SS=D	Continued from page 118 Based on personnel record review, and staff interview, it was determined that the facility failed to provide abuse, neglect and exploitation training at the time of hire for four of six staff reviewed (Employee E26, E27, E28, and E29). Findings: A review of the Facility Policy titled " Abuse" revised on June 30, 2023, revealed Centers prohibit abuse, mistreatment, neglect, misappropriation of resident/ patient (hereinafter "patient"), and exploitation for all patients. The center will implement an abuse prohibition program through the following: Screening of potential hires: training of employees (both new employees and ongoing training for all employees." Reviewed six new hires employee records revealed the following: -Licensed practical nurse, Employees E26 hired on March 1, 2025, abuse training was not completed	F 0943		

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F 0943 SS=D	Continued from page 119 until April 2, 2025, -Register nurse,Employee E27 was hired on February 10, 2025, abuse training was completed until March 14, 2025. -Nurse aide, Employee E28 was hired on March 1, 2025, abuse training was completed until on April 11, 2025. -Register nurse, Employee E29 was hire on January 1, 2025, there was no documented evidence that abuse training was completed. An interview was conducted with Human Resources staff, Employee E30 on April 25, 2025, sat 1:42 p.m., it was confirmed that the employees above had late abuse training done, and one register nurse didn't have the abuse training done. 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 201.19(8) Personnel policies and procedures	F 0943		

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H 0009	51.3 (g)(1-14) NOTIFICATION 51.3 Notification (g) For purposes of subsections (e) and (f), events which seriously compromise quality assurance and patient safety include, but not limited to the following: (1) Deaths due to injuries, suicide or unusual circumstances. (2) Deaths due to malnutrition, dehydration or sepsis. (3) Deaths or serious injuries due to a medication error. (4) Elopements. (5) Transfers to a hospital as a result of injuries or accidents. (6) Complaints of patient abuse, whether or not confirmed by the facility. (7) Rape. (8) Surgery performed on the wrong patient or on the wrong body part. (9) Hemolytic transfusion reaction. (10) Infant abduction or infant discharged to the wrong family. (11) Significant disruption of services due to disaster such as fire, storm, flood or other occurrence. (12) Notification of termination of any services vital to continued safe operation of the facility or the	H 0009	A – Resident's morphine was replaced at the cost of the facility and not charged to resident's insurance. B – Audit of all reportable incidents in last 30 days to ensure reported accurately. C – Previous DON and NHA educated on proper classification of reportable incidents of misappropriation in the PA event reporting system. Current DON and NHA aware of reporting category. D – Weekly x 4 then monthly x 2 audits by regional nurse or designee of reportable incidents to ensure accurate reporting. Results discussed during QAPI meetings.	Completion Date: 06/23/2025 Status: APPROVED Date: 05/23/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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H 0009	Continued from page 1 health and safety of its patients and personnel, including, but not limited to, the anticipated or actual termination of electric, gas, steam heat, water, sewer and local exchange of telephone service. (13) Unlicensed practice of a regulated profession. (14) Receipt of a strike notice. This REGULATION is not met as evidenced by:	H 0009		

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H 0009	Continued from page 2 Based on clinical record review and interview with staff, it was determined that the facility failed to accurately report an incident of misappropriation of narcotics for one of four facility reported incidents reviewed. Findings include: Review of clinical documentation revealed that an investigation had been conducted regarding misappropriation of medication when it was discovered that the morphine 20MG/ML bottles for Residents R69 and R262 had been tampered with. The facility entered the incident into the state reporting system under the category of "other". Interview with the Nursing Home Administrator, employee E1, and the Director of Nursing, employee E2 on April 24, 2025, at 2:30 p.m. confirmed that this incident should have been reported under the category of "misappropriation of patient/resident property", and was inaccurately recorded. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(1) Management 28 Pa Code 201.18(e)(1) Management	H 0009		

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P 5520	Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	A – N/A B – Staffing Coordinator will staff the daily nursing staff to meet the required CNA to resident ratio of 1:10 on 7-3, 1:11 on 3-11, and 1:15 on 11-7. C – NHA, DON, and Staffing Coordinator educated on minimum staff to resident ratio. D – Weekly x4 then monthly x2 random audits by DON or designee of Cna staff ratio on 50% of days to ensure compliance with ratios	Completion Date: **06/23/2025** Status: **APPROVED** Date: **05/30/2025**

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P 5520	Continued from page 1 Based on a review of nursing staffing hours and staff interview, it was determined that the facility did not ensure a minimum of one nurse aide (NA) for every 12 residents on the day shift for four of 21 days reviewed, one NA for every 12 residents on the evening shift for seven of 21 days reviewed, and one NA for every 20 residents during the night shift on 11 of 21 days reviewed. Findings include: Review of nursing staff care hours provided by the facility revealed the following staff scheduled for the resident census: Day shift (requires one NA per 12 residents) February 13, 2025, 10.8 NAs, with a census of 114 residents, required 11.4 NAs. February 14, 2025, 8.5 NAs, with a census of 114 residents, required 11.4 NAs. February 15, 2025, 9.8 NAs, with a census of 113 residents, required 11.3 NAs.	P 5520		

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P 5520	Continued from page 2 April 20, 2025, 10.6 NAs, with a census of 111 residents, required 11.1 NAs. April 22, 2025, 10.6 NAs, with a census of 109 residents, required 10.9 NAs. April 23, 2025, 10.6 NAs, with a census of 108 residents, required 10.8 NAs. April 24, 2025, 10.57 NAs, with a census of 108 residents, required 10.8 NAs. Evening shift (requires one NA per 12 residents) February 9, 2025, 8.47 NAs, with a census of 109 residents, required 10 NAs. February 14, 2025, 9.13 NAs, with a census of 114 residents, required 10.36 NAs. February 15, 2025, 9.8 NAs, with a census of 113 residents, required 11.3 NAs. April 20, 2025, 8.7 NAs, with a census of 110 residents, required 10 NAs. Night shift (requires one NA per 20 residents) February 9, 2025, 4.27 NAs, with a census of 110 residents, required 7.33 NAs. February 10, 2025, 6.53 NAs, with a census of	P 5520		

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P 5520	Continued from page 3 111 residents, required 7.4 NAs. February 11, 2025, 5.67 NAs, with a census of 112 residents, required 7.47 NAs. February 12, 2025, 6.4 NAs, with a census of 114 residents, required 7.6 NAs. February 14, 2025, 7.2 NAs, with a census of 115 residents, required 7.67 NAs. February 15, 2025, 6 NAs, with a census of 113 residents, required 7.53 NAs. April 18, 2025, 6.83 NAs, with a census of 111 residents, required 7.4 NAs. April 19, 2025, 5.63 NAs, with a census of 111 residents, required 7.4 NAs. April 20, 2025, 6.03 NAs, with a census of 110 residents, required 7.33 NAs. April 22, 2025, 5.1 NAs, with a census of 108 residents, required 7.2 NAs. April 23, 2025, 7.13 NAs, with a census of 108 residents, required 7.2 NAs. Interview with the Nursing Home Administrator, Employee E1, and the Director of Nursing, Employee E2, on April 25, 2025, at 2:00 p.m.,	P 5520		

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P 5520	Continued from page 4 confirmed that the above staffing levels did not meet the required minimums.	P 5520		
P 5640	Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	A – N/A B - Staffing Manager or designee will staff the daily nursing staff to meet the required ppd minimum 3.2 for direct res care C - NHA, DON, and Staffing Coordinator educated on PA required PPD requirement D – Weekly x 4 then monthly x 2 audits by NHA or designee on PPD levels. Results discussed during QAPI meetings.	Completion Date: **06/23/2025** Status: **APPROVED** Date: **05/30/2025**

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P 5640	Continued from page 5 Based on a review of nursing staffing hours and staff interview, it was determined that the facility did not ensure a minimum of 3.2 nursing care hours per patient, per day, on five of 21 days reviewed (February 9, 14 and 15, 2025, and April 20 and 22, 2025) Findings include: Review of nursing staff care hours provided by the facility revealed the following staff scheduled for the resident census: February 9, 2025, 328.5 care hours with a census of 110 residents, totaling 2.99 PPD. February 14, 2025, 333 care hours with a census of 115 residents, totaling 2.9 PPD. February 15, 2025, 323.75 care hours with a census of 113 residents, totaling 2.87 PPD. April 20, 2025, 352.75 care hours with a census of 111 residents, totaling 3.18 PPD. April 22, 2025, 337 care hours with a census of	P 5640		

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P 5640	Continued from page 6 109 residents, totaling 3.09 PPD. Interview with the Nursing Home Administrator, Employee E1, and the Director of Nursing, Employee E2, on April 25, 2025, at 2:00 p.m., confirmed that the above staffing levels did not meet the required minimums.	P 5640		

Certified End Page

COMPLETE CARE AT HARSTON HALL LLC

STATE LICENSE NUMBER: 080702

SURVEY EXIT DATE: 04/25/2025

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

Jeanne Parisi
Deputy Secretary for Quality Assurance

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

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY