STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395891	A. BLDG: 00 B. WING:	04/16/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
LAUREL VIEW VILLAGE STATE LICENSE NUMBER: 043702	2000 CAMBRIDGE DRIVE DAVIDSVILLE, PA 15928

(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, and Civil Rights Compliance survey completed on April 16, 2025, it was determined that Laurel View Village was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0641 SS=D		F 0641		

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 0641 SS=D	Continued from page 1 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	Minimum Data Set (MDS) assessment for Residents 28,38,23,15 was updated and resubmitted. Residents who have a Minimum Data Set (MDS) completed and require coding related to care needs have the potential to be affected. These individuals Minimum Data set were reviewed for accuracy. Education will be obtained for both Nursing Home Administrator, Registered Nurse Assessment Coordinator (RNAC), the Employee responsible for completion of the assessment, and any other individuals responsible for coding and/or auditing of the Minimum Data Set. Registered Nurse Assessment Coordinator reviewed the accuracy of assessments related to coding residents' abilities and care needs via Resident Assessment Instrument (RAI)manual. Registered Nurse Assessment Coordinator (RNAC) will reference the 3.0 Drug Class Index to confirm	Completion Date: **06/02/2025** Status: **APPROVED** Date: **05/02/2025**

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F 0641 SS=D	Continued from page 2	F 0641	drug class when completing Section N (N0415. High risk Drug Classes : Use and Indication) of the Minimum Data Set Version 3.0 to assist and ensure accuracy of the Minimum Data Set. Updated 3.0 Drug Class Index obtained to ensure all classifications are accurate and reflective of any new medications. Director of Compliance or Designee will ensure Compliance going forward through auditing of the Minimum Data Set. The auditing will occur at the following schedule. 2 Clinical Records weekly for 4 weeks. Followed by 4 clinical records twice monthly for 2 months. On-the-spot education will be provided to staff as needed. The results of these logs/audits along with a Root Cause Analysis of any identified issues will be brought to the Quality Assurance and Performance Improvement Committee for two quarters for	

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F 0641 SS=D	Continued from page 3	F 0641	further analysis and corrective action as needed. The committee will determine the need for additional audits or reporting.	

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F 0641 SS=D	Continued from page 4 Based on review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set assessments for four of 29 residents reviewed (Residents 15, 23, 28, 38). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides guidance and instructions for the completion of MDS assessments, dated October 2024, indicated that the intent of Section N was to record the number of days, during the seven-day assessment period, that any type of injection, insulin, and/or select medications were received by the resident. Section N0415B1 was to be coded if the resident received an antianxiety medication during the seven-day assessment period, Section N0415F1 was to be coded if the resident received an antibiotic medication during the seven-day assessment period, Section N0415G1 Diuretic	F 0641		

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F 0641 SS=D	Continued from page 5 Medications (medications that promote the excretion of urine by the kidneys) was to be coded if the resident took the medication during the seven-day assessment period, and Section N0451K1 was to be coded if the resident received an anticonvulsant (medication used to prevent seizures) medication during the seven-day assessment period. Physician's orders for Resident 15, dated February 5, 2024, included an order for the resident to receive 320-12.5 mg of Valsartan-hydrochlorothiazide (antihypertensive - diuretic medication) daily for hypertension (high blood pressure). Medication Administration Records (MAR's) for Resident 15, dated January 2025, revealed that staff administered 320-12.5 mg of valsartan-hydrochlorothiazide daily from January 1 through 31, 2025. However, Section N0415G1 of Resident 15's quarterly MDS assessment, dated January 16, 2025, was coded to indicate that the resident did not receive a diuretic medication during the seven-day assessment.	F 0641		

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F 0641 SS=D	Continued from page 6 Physician's orders for Resident 23, dated July 23, 2024, included an order for the resident to receive 0.5 mg of lorazepam (an antianxiety medication) four times a day for post traumatic stress disorder. MAR's for Resident 23, dated January 2025, revealed that staff administered 0.5 mg of lorazepam four times a day from January 1 through 31, 2025. However, Section N0415B1 of Resident 23's quarterly MDS assessment, dated January 25, 2025, was coded to indicate that the resident did not receive an antianxiety medication during the seven-day assessment. Physician's orders for Resident 28, dated January 27, 2025, included an order for staff to apply 1 percent Silver Sulfadiazine cream (topical antibiotic cream used to prevent infections) to open areas on the resident's coccyx and right buttocks every evening. Treatment Administration Records (TAR's) for Resident 28 for February 2025 revealed that staff applied 1 percent Silver Sulfadiazine to the resident's coccyx and right	F 0641		

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F 0641 SS=D	Continued from page 7 buttocks every evening from February 1 through 9, 2025. However, Section N0415F1 of Resident 28's annual MDS assessment, dated February 15, 2025, was coded to indicate that the resident did not receive an antibiotic medication during the seven-day assessment. Physician's orders for Resident 38, dated September 25, 2024, included an order for the resident to receive 100 mg of carbamazepine (anti-convulsant medication used to treat neuralgia) at bedtime for neuralgia (nerve pain). MAR's for Resident 38, dated December 2024, revealed that staff administered 100 mg of carbamazepine at bedtime from December 1 through 31, 2024. However, Section N0415K1 of Resident 38's quarterly MDS assessment, dated December 30, 2024, was coded to indicate that the resident did not receive an anticonvulsant medication during the seven-day assessment. Interview with Registered Nurse Assessment Coordinator 1 (RNAC - a registered nurse who is	F 0641		

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F 0641 SS=D	Continued from page 8 responsible for the completion of MDS assessments) on April 15, 2025, at 11:20 a.m. confirmed that MDS assessments for Residents 15, 23, 28, and 38 were coded inaccurately. 28 Pa. Code 211.5(f) Clinical Records.	F 0641		
F 0676 SS=D		F 0676		

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F 0676 SS=D	Continued from page 9 483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting,	F 0676	An immediate remedy could not be implemented for Resident 29 as events occurred in the past. To ensure compliance and accuracy going forward. Active range of motion for the certified nursing assistant to complete was added to this resident. An audit/review of all other residents' restorative nursing plan was completed. Active range of motion for the certified nursing assistant was added to those residents who had an active range of motion program assigned to the Restorative Nursing Assistant. The Restorative Nursing Program policy was reviewed by Nursing Management and Medical Director; The Policy was updated. This Policy will be educated and reviewed with All current Healthcare Nursing Staff and acknowledgements will be obtained and documented. All newly hired	Completion Date: 06/02/2025 Status: APPROVED Date: 05/02/2025

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F 0676 SS=D	Continued from page 10 §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by:	F 0676	staff as well as temporary (agency) staff are to be educated on Restorative Nursing Program/Policy Schedule and Execution of Tasks An additional Restorative Nursing Assistant to fill in when the Restorative Nurse Aide is absent has been identified and trained. The Director of Nursing, Assistant Director of Nursing, Healthcare Nursing Leadership, or designee will conduct audits for staff compliance with documentation of the Restorative Nursing Program daily for two weeks, then weekly for six weeks, then monthly for four months. On-the-spot education will be provided to staff as needed. The results of these logs/audits along with a Root Cause Analysis of any identified issues will be brought to the Quality Assurance and Performance Improvement Committee for two quarters for further analysis and corrective	

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F 0676 SS=D	Continued from page 11	F 0676	action as needed. The committee will determine the need for additional audits or reporting.	

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F 0676 SS=D	Continued from page 12 Based on a review of facility policies and clinical records, as well as resident and staff interviews, it was determined that the facility failed to ensure that restorative nursing programs to maintain or improve physical abilities were provided as per the resident's plan of care for one of 29 residents reviewed (Resident 39). Findings include: A facility policy regarding restorative nursing programs, dated December 2024, indicated that each resident involved will have an individualized program with a realistic and measurable goal. The restorative nursing program is designed to assist each resident to achieve and maintain an optimal level of self-care, independence and quality of life. Through the resident's care plan, the goals of the restorative nursing program are reinforced in the restorative services. Restorative aides/designee will be responsible for documenting how the resident did, how far they may have ambulated, how long	F 0676		

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F 0676 SS=D	Continued from page 13 they stood for, or how many repetitions of exercise were performed. And if there were any issues to what they were, what was done and who was made aware. The restorative nursing coordinator will oversee the restorative nursing programs and documentation. A monthly summary assessment is to be completed by the restorative nursing aide/designee to include changes and adjustments, progress towards goals, and the needs to continue or discharge, as per team recommendations. Each resident program will be evaluated monthly for any significant change in function and discussed and revised as needed. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 39, dated January 19, 2025, revealed that the resident was cognitively intact, required substantial/maximum assistance (helper provides more than half of the effort required to complete a task) with lower body dressing, moderate assistance (resident performs about half the effort required for an activity) with upper body	F 0676		

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F 0676 SS=D	Continued from page 14 dressing, substantial/maximum assistance with transfers and ambulation, was able to ambulate 10 feet with substantial/maximum assistance, and had a diagnosis of Parkinsonism (a neurological disorder causing slowed movements, stiffness and tremors). A care plan intervention for Resident 39, revised on December 2, 2024, indicated that the resident was on a restorative active range of motion (performance of an exercise to move a joint without any assistance or effort of another person to the muscles surrounding the joint) program to his bilateral upper extremities using five-pound weights with a goal of two sets for 15 repetitions. A care plan intervention for Resident 39, revised on December 2, 2024, indicated that the resident was on a restorative ambulation program, and he was to be walked with limited assistance (resident is highly involved in performing an activity) from one person and use of a front-wheeled walker and with a wheelchair follow for a goal of 100 feet. The restorative active range of motion and ambulation was to be documented on the activity of daily living flowsheet.	F 0676		

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F 0676 SS=D	Continued from page 15 Review of Resident 39's restorative active range of motion documentation from February 1, 2025, through April 14, 2025, as well as review of nursing notes, revealed no documented evidence that the restorative active range of motion program was completed as per the resident's plan of care on the day shift for the following dates: February 1, 2, 4, 8, 9, 15, 16, and 18-28; March 1, 2, 3, 8, 9, 15, 16, 17, 20, 22, 23, 29 and 30; and April 3, 5, 6, 12, and 13. Review of Resident 39's restorative ambulation documentation from February 1, 2025, through April 14, 2025, as well as review of nursing notes, revealed no documented evidence that the restorative ambulation program was completed as per the resident's plan of care on the day shift for the following dates: February 2, 14,16, 18, 22, 23 and 25; March 4, 5, 6, 9, 17, 18, 19, 20, 23, 24, 28, 30 and 31; and April 2, 4, 5, 6, 7, 8, 9, 10, 11, 13 and 14. Review of Resident 39's restorative ambulation	F 0676		

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F 0676 SS=D	Continued from page 16 documentation from February 1, 2025, through April 14, 2025, as well as review of nursing notes, revealed that there was no documented evidence that the restorative ambulation program was completed as per the resident's plan of care on the evening shift for the following dates: February 2, 4, 5, 7, 8, 9, 13-18, and 20-28; March 1, 4, 6, 8-14, 17, 18, 19, 21-27, 29, 30 and 31; and April 1- 6, 8, 9 and 10. A monthly restorative review for Resident 39, dated January 23, 2025, indicated that the resident participates with range of motion exercise with the restorative aide and staff, and that he ambulates with a wheeled walker and limited assistance from two staff to his tolerance in his room. A monthly restorative review for Resident 39, dated March 5, 2025, indicated that the resident participates with range of motion exercise with the restorative aide and staff, and that he ambulates with a wheeled walker and limited assistance from two staff to his tolerance in his room. A monthly restorative review for Resident 39, dated March 24, 2025, indicated	F 0676		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395891	A. BLDG: 00 B. WING:	04/16/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
LAUREL VIEW VILLAGE STATE LICENSE NUMBER: 043702	2000 CAMBRIDGE DRIVE DAVIDSVILLE, PA 15928

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F 0676 SS=D	Continued from page 17 that the resident participates with range of motion exercise with the restorative aide and staff, and that he ambulates with a wheeled walker and limited assistance from two staff to his tolerance in his room. An interview with Nurse Aide 2 on April 16, 2025, at 8:14 a.m. revealed that she only walks Resident 39 in his room from his bed to his recliner chair at beside. She indicated that she would attempt to walk him to his bathroom some days, but he was usually unable to walk that far. An interview with the Nursing Home Administrator on April 16, 2025, at 11:08 a.m. confirmed that there was no documented evidence that Resident 39's restorative active range of motion and ambulation programs were completed as per his care plan on the above-mentioned dates and shifts. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.	F 0676		

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F 0684 SS=E		F 0684		

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F 0684 SS=E	Continued from page 19 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	(Bowel) An Immediate Remedy could not occur for Resident 4 and 41 in this situation as the events occurred in the past. A audit/review of all other current residents in the facility shows that all residents have had appropriate administration of all bowel protocols where necessary. The Bowel Protocol Policy was reviewed and updated by Nursing Administration and Medical Director. This Policy will be educated and reviewed with All current Healthcare Nursing Staff and acknowledgements will be obtained and documented. All newly hired staff as well as temporary (agency) staff are to be educated on the bowel protocol policy. The Director of Nursing, Assistant Director of Nursing, Healthcare Nursing Leadership, or designee will	Completion Date: 06/02/2025 Status: APPROVED Date: 05/05/2025

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F 0684 SS=E	Continued from page 20	F 0684	conduct audits for staff compliance with the Bowel Protocol Policy three times a week for two weeks, then weekly for six weeks, then monthly for four months. On-the-spot education will be provided to staff as needed. The results of these logs/audits along with a Root Cause Analysis of any identified issues will be brought to the Quality Assurance and Performance Improvement Committee for two quarters for further analysis and corrective action as needed. The committee will determine the need for additional audits or reporting. (Patch) An Immediate Remedy could not occur for Resident 27 as this situation as the events occurred in the past. An audit/review of orders was completed	

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F 0684 SS=E	Continued from page 21	F 0684	with no other resident prescribed as needed topical patches. The Transdermal Patch Policy was reviewed and updated by the Nursing Administration and Medical Director. This Policy will be educated and reviewed with All current Healthcare Nursing Staff and acknowledgements will be obtained and documented. All newly hired staff as well as temporary (agency) staff are to be educated on the bowel protocol policy. The Director of Nursing, Assistant Director of Nursing, Healthcare Nursing Leadership, or designee will conduct audits for staff compliance with the documentation of removal of as needed transdermal patches three times a week for two weeks, then weekly for six weeks, then monthly for four months. On-the-spot education will be provided to staff as needed. The	

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F 0684 SS=E	Continued from page 22	F 0684	results of these logs/audits along with a Root Cause Analysis of any identified issues will be brought to the Quality Assurance and Performance Improvement Committee for two quarters for further analysis and corrective action as needed. The committee will determine the need for additional audits or reporting.	

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F 0684 SS=E	Continued from page 23 Based on clinical record reviews and staff interviews, it was determined that the facility failed to follow physician's orders related to bowel protocols for two of 29 residents reviewed (Residents 4, 41) and failed to follow physician's orders for medication administration for one of 29 resident (Resident 27). Findings include: A facility policy for the bowel protocol, dated November 2021, indicated that on admission the following bowel protocol will be ordered for all residents to prevent constipation unless otherwise specified by the admitting physician. Give 30 milliliters (ml) of Milk of Magnesia (MOM - an oral laxative) one time if there is not bowel movement after 3 days. If Milk of Magnesia is ineffective, on day 4, give a 10 milligram (mg) Dulcolax suppository (a laxative inserted rectally). If both Milk of Magnesia and Dulcolax suppository are ineffective, on day 5 give a Fleets enema (a liquid inserted rectally to stimulate a bowel movement)	F 0684		

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F 0684 SS=E	Continued from page 24 unless contraindicated. Monitor the use of the bowel protocol. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated February 27, 2025, indicated that the resident was cognitively impaired, was dependent on staff for daily care needs, and had diagnoses that included dementia. Current physician's orders for Resident 4 included orders for staff to administer 30 milliliters (ml) of Milk of Magnesia as needed for no bowel movement after three days; a 10 milligram (mg) Dulcolax suppository as needed if Milk of Magnesia was not effective, to be administered on day 4 if no bowel movement; and to administer a Fleets enema as needed if Milk of Magnesia and Dulcolax suppository are ineffective, to be administered on day 5 of no bowel movement. Review of the bowel record for Resident 4, dated March 2025, indicated that the resident did not have	F 0684		

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F 0684 SS=E	Continued from page 25 a bowel movement on March 17 through March 23, 2025, a total of seven days. Review of the Medication Administration Record (MAR) for Resident 4, dated March 2025, indicated that 30 ml of Milk of Magnesia was administered to the resident on March 20 with ineffective results. Review of the MAR revealed no documented evidence that Dulcolax was administered when Milk of Magnesia was ineffective on day 4 of not having a bowel movement as ordered, and no documented evidence that a Fleets enema was administered on day 5 of no bowel movement, as ordered. An admission MDS assessment for Resident 41, dated February 3, 2025, indicated that the resident was cognitively impaired, was dependent on staff for daily care needs, was frequently incontinent of bowel movements, and had diagnoses that included dementia. Physician's orders for Resident 41, dated January	F 0684		

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F 0684 SS=E	Continued from page 26 28, 2025, included orders for staff to administer 30 ml of Milk of Magnesia as needed for no bowel movement after three days, a 10 mg Dulcolax suppository as needed if Milk of Magnesia was not effective on day 4 if no bowel movement, and to administer a Fleets enema as needed for constipation on day 5 if both Milk of Magnesia and Dulcolax suppository were ineffective. Review of the bowel records for Resident 41, dated February and April 2025, indicated that the resident did not have a bowel movement on February 2 through 6, 2025, (6 days) and on April 7 through April 11, 2025, (five days). Review of the Medication Administration Record (MAR) for Resident 41, dated February and April 2025, indicated that 30 ml of Milk of Magnesia and the Dulcolax suppository were not administered on the third and fourth day without a bowel movement, as ordered by the physician. Interview with the Nursing Home Administrator on April 16, 2025, at 11:26 a.m. confirmed that bowel	F 0684		

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F 0684 SS=E	Continued from page 27 protocol was not followed for Residents 4 and 41 on the above-mentioned dates. A quarterly MDS assessment for Resident 27, dated January 31, 2025, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnoses that included left-sided hemiplegia (paralysis or weakness on one side of the body) after having a stroke. Current physician's orders for Resident 27 indicated that the resident was to receive a Salonpas patch to her left or right shoulder as needed for pain daily, and to remove the Salonpas patch no more than 12 hours after the application. Review of the MAR for Resident 27 dated February, March, and April 2025 revealed that a Salonpas patch was administered to Resident 27 on February 1 at 9:33 a.m., February 5 at 6:45 a.m., February 6 at 6:05 a.m., February 7 at 6:44 a.m., February 10 at 5:27 a.m., February 12 at 6:44 a.m.,	F 0684		

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F 0684 SS=E	Continued from page 28 February 17 at 6:51 a.m., February 19 at 9:37 a.m., March 1 at 6:57 a.m., March 4 at 7:05 a.m., March 6 at 7:21 a.m., March 10 at 5:27 a.m., March 16 at 7:00 a.m., March 17 at 7:18 a.m., March 18 at 9:53 a.m., March 20 at 6:47 a.m., March 30 at 8:24 a.m., April 1 at 6:40 a.m., April 7 at 6:40 a.m., April 8 at 6:27 a.m., and April 12 at 6:01 a.m. There was no documented evidence that the Salonpas patch was removed within 12 hours of applying it as ordered. Interview with the Nursing Home Administrator on April 15, 2025, at 11:34 a.m. confirmed that there was no documented evidence that the Salonpas patch was removed from Resident 27 within 12 hours after it was applied as ordered on the above mentioned dates. 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0684		

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F 0690 SS=D		F 0690		

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F 0690 SS=D	Continued from page 30 483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 0690	The remedy could not be immediate as the events occurred in the past. All residents with Urinary Catheters were identified and a documentation Audit was completed. The Input and Output Measurement policy was reviewed and updated. This Policy will be educated and reviewed with All current Healthcare Nursing Staff and acknowledgements will be obtained and documented. All newly hired staff as well as temporary (agency) staff and Hospice Agencies that provide care are to be educated on the documentation of output. The Director of Nursing, Assistant Director of Nursing, Healthcare Nursing Leadership, or designee will conduct audits for staff compliance with documentation of output in indwelling catheters three times weekly for two weeks, then weekly for six weeks, then monthly for four months.	Completion Date: **06/02/2025** Status: **APPROVED** Date: **05/02/2025**

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F 0690 SS=D	Continued from page 31 This REQUIREMENT is not met as evidenced by:	F 0690	On-the-spot education will be provided to staff as needed. The results of these logs/audits along with a Root Cause Analysis of any identified issues will be brought to the Quality Assurance and Performance Improvement Committee for two quarters for further analysis and corrective action as needed. The committee will determine the need for additional audits or reporting. (Catheter Bag touching the Floor) Upon immediate investigation it was determined that all necessary supplies were in place to ensure that residents Urinary Catheter and any accompanying tubing were not in direct contact with the floor, however due to the residents bed being place in the appropriate care Planned position, the bed frame had inadvertently crushed the basin allowing for the tubing and bag to be in contact with the floor. As this facility considers this a random	

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F 0690 SS=D	Continued from page 32	F 0690	unusual occurrence, the following will be completed in efforts to ensure that staff continue to remain educated and diligent in ensuring the mentioned deficiency does not occur. Policy was reviewed for accuracy and appropriateness The Director of Nursing, Assistant Director of Nursing (Infection Preventionist), Healthcare Nursing Leadership, or designee will conduct visual audits for staff compliance with ensure urinary Catheter Bags and Tubing are meeting Infection Control Standards three times weekly for two weeks, then weekly for six weeks, then monthly for four months. On-the-spot education will be provided to staff as needed. The results of these logs/audits along with a Root Cause Analysis of any identified issues will be brought to the Quality Assurance and Performance Improvement	

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F 0690 SS=D	Continued from page 33	F 0690	Committee for two quarters for further analysis and corrective action as needed. The committee will determine the need for additional audits or reporting.	

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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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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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 0690 SS=D	Continued from page 34 Based on review of facility policies and clinical records, as well as observation and staff interviews, it was determined that the facility failed to ensure that residents received proper care for indwelling urinary catheters and failed to ensure that urinary output was measured and documented per facility policy for one of 29 residents reviewed (Resident 39) who had an indwelling urinary catheter. Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 39, dated January 19, 2025, revealed that the resident was cognitively intact, required assistance with care needs, had an indwelling urinary catheter (a thin, flexible tube inserted into the bladder to drain urine from the bladder), and had a diagnosis of obstructive uropathy (blockage of the urinary tract). Physician's orders for Resident 39, dated February 10, 2025, included an order for suprapubic catheter	F 0690		

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F 0690 SS=D	Continued from page 35 (a type of indwelling catheter that drains urine from the bladder through the abdomen), 18 French (size) with a 10 cubic centimeters (cc) balloon (located on the bladder end of the catheter and filled with sterile water to hold the tube in place). Observations of Resident 39 on April 16, 2025, at 8:06 a.m. revealed that the resident was lying in bed with his catheter bag and tubing lying on the floor. There was no privacy bag or other type of barrier between the bag and the floor. Interview with Nurse Aide 2 on April 16, 2025, at 8:14 a.m. confirmed that Resident 39's catheter bag and tubing was lying in direct contact with the floor. She indicated that he had a basin that the catheter bag should have been in and located the basin under his bed. Interview with the Nursing Home Administrator on April 16, 2025, at 12:08 p.m. confirmed that the catheter bag and tubing should not have been in direct contact with the floor and should have been in	F 0690		

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F 0690 SS=D	Continued from page 36 a basin. The facility's policy regarding intake and output measurement, dated December 2024, indicated that all residents with an indwelling catheter require measurement and documentation of intake and output every shift . Daily intake and output records are maintained via the electronic medical record. Review of Resident 39's activity of daily living record from February 1, 2025, through April 14, 2025, revealed that there was no documented evidence that the resident's urinary output was measured on the day shift for the following dates: February 2 and 19; March 2, 4, 7, 22, 23, 24, 28 and 30; and April 4, 5, and 14. There was no documented evidence that the resident's urinary output was measured on the evening shift for the following dates: March 1, 7 and 20; and April 10. There was no documented evidence that the resident's urinary output was measured on the night shift for the following dates: February 11, 18, 27 and 28; and March 1, 20, 21, 22, and 31.	F 0690		

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F 0690 SS=D	Continued from page 37 Interview with the Nursing Home Administrator on April 16, 2025, at 11:42 a.m. confirmed that there was no documented evidence that Resident 39's urinary outputs were measured per facility policy on the above-mentioned dates and shifts. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0690		
F 0692 SS=D		F 0692		

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F 0692 SS=D	Continued from page 38 483.25(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	(Magic Cup) Immediately for Resident 12, Order was obtained for Magic Cup and added to resident tray ticket. An audit/review of all other current residents in the facility ordered supplements/interventions were reviewed for accuracy and appropriateness. Policy was Reviewed by Dietary Management, Medical Director, Nursing Administration and Dietician for accuracy. This Policy will be educated and reviewed with All current Registered Nurses and Dieticians; acknowledgements will be obtained and documented. All newly hired staff as well as temporary (agency) staff are to be educated, as necessary. Dietary Management or Designee will inspect the supplements provided at meal service. Audits will be completed with one meal per day	Completion Date: **06/02/2025** Status: **APPROVED** Date: **05/02/2025**

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F 0692 SS=D	Continued from page 39	F 0692	x 7 days for two weeks. Then one meal per day x 3 days for two weeks. Finally, one meal a day x 1 day for one week .and/or as needed Dietitian or Designee will Audits items ordered in Care plans, physician orders and tickets/labeled snacks as appropriate. The Dietician is the responsible Dietary staff member who reviews and accepts orders in Electronic Medical Record (EMR) to know if supplements are being consumed. Dietician Audits for Care plans, physician orders and tickets/labeled snacks as appropriate Audits need to be completed once weekly x 5 weeks and/or with changes to supplement orders. On-the-spot education will be provided to staff as needed. The results of these logs/audits along with a Root Cause Analysis of any identified issues will be brought to the Quality Assurance and Performance Improvement Committee for two quarters for further analysis and corrective	

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F 0692 SS=D	Continued from page 40	F 0692	action as needed. The committee will determine the need for additional audits or reporting.	

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F 0692 SS=D	Continued from page 41 Based on a review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that interventions to prevent weight loss were provided as recommended by the dietician for one of 29 residents reviewed (Resident 12). Findings include: A facility policy for nutrition interventions, dated October 2024, indicated that the dietician/qualified nutrition professional identifies residents who are at risk and/or potential risk for nutrition-related problems. The dietician/qualified nutrition professional recommends interventions to maintain the resident's nutrition status, based on resident preference and tolerance. For residents at nutritional risk, the dietician/qualified nutrition professional updates nutrition prescriptions per community ordering writing standards, for example, diet orders, supplements, med pass, and nourishment, and monitors resident's	F 0692		

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F 0692 SS=D	Continued from page 42 acceptance/outcomes on a regular basis and recommends changes. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 12, dated March 21, 2025, revealed that the resident had cognitive impairment, required set up and clean up assistance with eating, had diagnoses that included dementia, and had unplanned weight loss. Orders for Resident 12, dated April 3, 2025, included for the resident to have a regular mechanical soft diet with ground meats and nectar thick liquids. A dietary note for Resident 12, dated March 20, 2025, indicated that Resident 12 was agreeable to adding ice cream twice a day to her diet due to her weight loss and decreased food intake, and that the resident was to be given ice cream twice a day. Review of Resident 12's clinical record revealed no	F 0692		

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F 0692 SS=D	Continued from page 43 documented evidence that ice cream was provided to the resident twice a day per the dietician's recommendation. Review of the weight record for Resident 12 revealed that on March 17, 2025, the resident had a weight of 130.7 pounds (lbs) and on April 14, 2025, the resident's weight was 125.5 lbs. Observation of Resident 12 on April 16, 2025, at 12:05 p.m. revealed that she was sitting in the dining room with her lunch meal in front of her. No ice cream or magic cup supplement was observed. Interview with the Dietician on April 16, 2025, at 1:21 p.m. revealed that Resident 12 refused most nutritional supplements offered but did agree to trying ice cream twice a day, and that she believed that Resident 12 was getting ice cream or a magic cup (frozen dessert that like ice cream when frozen but is a pudding after thawing) after her diet was changed to thickened liquids, with her meals. The dietician confirmed that ice cream twice a day was	F 0692		

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F 0692 SS=D	Continued from page 44 not listed on her meal ticket, and there was no documented evidence that it or an equivalent magic cup was being provided per her recommendation. Interview with Dietary Manager on April 16, 2025, at 1:37 p.m. revealed that when nutritional support items are added to a residents' diet, an order for it was usually added into the resident's clinical record and the item added to the resident's meal ticket; however, there was no order for Resident 12 to have ice cream twice a day per the dietician's recommendation, and it was not added to her meal ticket. There was no documented evidence that Resident 12 was receiving or refusing ice cream or a magic cup equivalent twice a day. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.	F 0692		
F 0810 SS=D		F 0810		

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F 0810 SS=D	Continued from page 45 483.60(g) Assistive Devices - Eating Equipment/Utensils §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by:	F 0810	Licensed Practical Nurse on the unit immediately provided Resident 23 with fresh food and appropriate divided plate. Immediately after meal services the Dietary Aid, which was responsible for providing the plate, was re-educated on the order for residents' adaptive equipment and noted that it was present on the meal ticket to ensure compliance. The Adaptive Equipment Policy was reviewed with no change needed. It will be educated and reviewed with All current staff which assist with meal service. Acknowledgements will be obtained and documented. All newly hired staff as well as temporary (agency) staff and Hospices which assist with meals are to be educated, as necessary. An audit/review was completed for all Adaptive equipment ordered for residents with a visual analysis on the equipment being noted on residents' meal tickets as well as	Completion Date: **06/02/2025** Status: **APPROVED** Date: **05/02/2025**

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F 0810 SS=D	Continued from page 46	F 0810	successful execution on providing appropriate equipment to the residents. Dietary Management or Designee will inspect the use of adaptive equipment at meal service. Audits to ensure compliance will occur at the following Schedule. Initially, one meal per day x 7 days for two weeks, followed by one meal per day x 3 days for two weeks and finally one meal a day x 1 day for one week and/or as needed. On-the-spot education will be provided to staff as needed. The results of these logs/audits along with a Root Cause Analysis of any identified issues will be brought to the Quality Assurance and Performance Improvement Committee for two quarters for further analysis and corrective action as needed. The committee will determine the need for additional audits or reporting.	

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F 0810 SS=D	Continued from page 47 Based on review of policies and clinical records, observations, and staff interviews, it was determined that the facility failed to ensure that staff provided assistive devices to eat as ordered by the physician for one of 29 residents reviewed (Resident 23). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 23, dated January 25, 2025, indicated that the resident was moderately cognitively impaired, required set-up assistance from staff with eating, and had diagnoses that included dementia. Physician's orders, dated February 14, 2024, included an order for the resident to utilize a divided plate (plate that allows easier access to food). Observations of Resident 23 during the lunch meal on April 15, 2025, at 12:02 p.m. revealed that the resident was in the dining room eating her meal and	F 0810		

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F 0810 SS=D	Continued from page 48 did not have a divided plate. The resident's meal ticket for the noon meal indicated that she was to have a divided plate. Interview with Licensed Practical Nurse 4 on April 15, 2025, at 12:04 p.m. confirmed that Resident 23 did not have a divided plate as ordered. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.	F 0810		
F 0867 SS=E		F 0867		

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F 0867 SS=E	Continued from page 49 483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including	F 0867	The current Quality Assurance Performance Improvement program has been reviewed by the Director of Quality and Compliance. The repeat deficiencies have been reviews and audits have been developed to provide accurate data collection and process improvement. Director of Quality and Compliance will review Quality Assurance and Performance Improvement Minutes. Education has been provided to the Interdisciplinary Team Regarding Repeat deficiencies. Audits for repeat deficiencies will be completed per their individual plan of corrections. All audits will be reviewed at Quality Assurance and Performance Improvement Quarterly meeting where a Root Cause Approach will Evaluate new and recurrent deficiencies. Revision or extension of audits will be discussed with the Interdisciplinary Team. Any audits that need to be reviewed will be done at that time.	Completion Date: **06/02/2025** Status: **APPROVED** Date: **05/02/2025**

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LAUREL VIEW VILLAGE STATE LICENSE NUMBER: 043702	2000 CAMBRIDGE DRIVE DAVIDSVILLE, PA 15928

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F 0867 SS=E	Continued from page 50 the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the	F 0867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395891	A. BLDG: __00_____ B. WING: _____	04/16/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0867 SS=E	Continued from page 51 incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:	F 0867		

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F 0867 SS=E	Continued from page 52 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by:	F 0867		

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F 0867 SS=E	Continued from page 53 Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to maintain compliance with nursing home regulations and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plans of correction for a State Survey and Certification (Department of Health) survey ending May 23, 2024, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending April 16, 2025, identified repeated deficiencies related to a failure to follow physician's orders, provide proper care of urinary catheters, and nutrition maintenance.	F 0867		

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F 0867 SS=E	Continued from page 54 The facility's plan of correction for a deficiency regarding following physician's orders, cited during survey ending May 23, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F684, revealed that the QAPI committee was ineffective in correcting deficient practices related to following physician's orders. The facility's plan of correction for a deficiency regarding failures to provide proper catheter care, cited during the survey ending May 23, 2024, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F690, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding catheter care. The facility's plan of correction for a deficiency regarding nutrition maintenance, cited during the	F 0867		

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F 0867 SS=E	Continued from page 55 survey ending on May 23, 2024, revealed that audits would be conducted, and the results of the audits would be brought before the QAPI committee for further monitoring. The results of the current survey, cited under F692, revealed that the QAPI committee was ineffective in maintaining compliance with the regulation regarding nutrition maintenance. Refer to F684, F690, F692. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.	F 0867		

Certified End Page

LAUREL VIEW VILLAGE

STATE LICENSE NUMBER: 043702

SURVEY EXIT DATE: 04/16/2025

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

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY