STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395913	A. BLDG: 00 B. WING:	07/28/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HUNTINGDON SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **053802**	**3430 HUNTINGDON PIKE HUNTINGDON VALLEY, PA 19006**

(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, State Licensure, and Civil Rights Compliance survey completed on July 28, 2025, it was determined that Huntingdon Skilled Nursing and Rehabilitation Center 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		
F 0655 SS=D		F 0655		

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.

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 0655 SS=D	Continued from page 1 483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:	F 0655	Residents 10, 13, and 19 care plans were updated to accurately reflect the resident's initial plan of care and families were made aware. All the residents have the potential to be affected by the deficient practice. All other residents in the facility were audited to ensure that baseline care plans are initiated within 48 hours of admission. All the pertinent departments will be educated on the policies and policies relating to the proper initiation of baseline care plan and accurate reflection of the baseline plan of care. Audits will be completed by the DON/Designee once a week for at least 3 residents for 3 months to ensure that the care plans are done for all new admissions within 48 hours of admission. All findings will be reported and reviewed by the QAPI committee monthly.	Completion Date: **08/26/2025** Status: **APPROVED** Date: **08/17/2025**

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 0655 SS=D	Continued from page 2 (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by:	F 0655	Date of Compliance: 08/26/2025	

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 0655 SS=D	Continued from page 3 Based on clinical record review, it was determined that the facility failed to develop and/or implement a baseline care plan that addressed individual resident needs for three of 20 sampled residents. (Residents 10, 13, 19) Findings include: Clinical record review revealed that Resident 10 was admitted to the facility on July 16, 2025, with diagnoses that included diabetes, heart failure, and muscle weakness. The baseline care plan dated July 16, 2025, noted that the resident was incontinent of bowel. There was no evidence that the care plan included interventions and goals to address Resident 10's incontinence. Clinical record review revealed that Resident 13 was admitted to the facility on July 21, 2025, with diagnoses that included diabetes and dysphagia (difficulty swallowing). There was no documented evidence that the facility developed a baseline care plan following admission.	F 0655		

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F 0655 SS=D	Continued from page 4 Clinical record review revealed that Resident 19 was admitted to the facility on July 22, 2025, with diagnoses that included depression and diabetes. On July 22, 2025, a nurse noted that the resident had a language barrier and had difficulty communicating. On July 23, 2025, the social worker documented that the resident's family was required to translate due to a language barrier. There was no documented evidence that the resident's language barrier was addressed in the baseline care plan. In an interview on July 28, 2025, at 4:15 p.m., the Director of Nursing confirmed there was no documented evidence that the care areas were addressed in the resident's baseline care plan. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.	F 0655		
F 0656 SS=D		F 0656		

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F 0656 SS=D	Continued from page 5 483.21(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. (B) The resident's preference and potential for future	F 0656	Resident 18 was updated to accurately reflect the goals of admission, preference for and potential for future discharge, discharge plan and services provided in the facility. Resident updated care plan included interventions for the following to address Resident's 18 urinary incontinence, dental care, self-care and mobility, and pressure ulcer were included in the care plan. All residents have the potential of being affected by the deficient practice. All other residents were audited to ensure that the care plans are comprehensive and reflective of the goals of admission, preferences for and potential for future discharge as well as discharge plans. Comprehensive care plans will be reviewed within days of the resident RAI assessment. All pertinent disciplines will be educated on the policies and procedures that reflect care plans which are reflective of the goals of	Completion Date: **08/26/2025** Status: **APPROVED** Date: **08/18/2025**

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F 0656 SS=D	Continued from page 6 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	admission, potential for future discharge and the discharge plans. An audit will be completed by the DON/Designee once a week for at least 3 residents for 6 weeks to ensure an accurate plan of care of residents that is reflective of the goals of admission, preferences/potential of discharge and discharge plans. All findings will be reported and reviewed by the QAPI committee monthly. Date of Compliance: 08/26/2025	

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F 0656 SS=D	Continued from page 7 Based on clinical record review and staff interview, it was determined that the facility failed to develop a comprehensive care plan that addressed individual resident needs as identified in the comprehensive assessment for one of 20 sampled residents. (Resident 18) Findings include: Clinical record review revealed that Resident 18 was admitted to the facility on July 15, 2025, and had diagnoses that included diabetes, heart failure, and dementia. The Minimum Data Set assessment and Care Area Assessment summary dated July 21, 2025, noted that the resident's urinary incontinence, dental care, self-care and mobility, and pressure ulcer was to be addressed in the care plan. There was no evidence that interventions to address Resident's 18 urinary incontinence, dental care, self-care and mobility, and pressure ulcer were included in the care plan. In an interview on July 28, 2025, at 4:00 p.m., the	F 0656		

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F 0656 SS=D	Continued from page 8 Director of Nursing confirmed there was no documented evidence that the care areas were addressed in the care plans. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0656		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 9 483.25 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	Physicians' orders were reviewed for all antihypertensive medications to ensure orders reflect parameters prior to medication administration. Physicians order was reviewed for all weights to ensure that orders are carried out and reported as ordered. All residents with antihypertensive medication and daily weights orders have the potential to be affected by the deficient practice. All other residents were audited to ensure that parameters are documented before medication administration and weights are documented and reported to accurately reflect doctor's orders. Nursing staff will be re-educated on the policies and procedures of medication administration and documentation to accurately reflect the doctor's orders. An audit will be completed by DON/Designee on all new admissions once a week for at least 3 residents for 6 weeks to ensure that	Completion Date: **08/26/2025** Status: **APPROVED** Date: **08/18/2025**

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F 0684 SS=D	Continued from page 10	F 0684	physician's orders are accurately reflected on the MAR/TARS All findings will be reported and reviewed by QAPI committee monthly x 3 months Date of Compliance: 08/26/2025	

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F 0684 SS=D	Continued from page 11 Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure physician's orders were implemented for two of 20 sampled residents. (Residents 1, 16) Findings include: Review of the policy entitled, "Medication Administration," last reviewed July 25, 2025, revealed staff were to obtain vital signs as necessary prior to medication administration and document physician indicated medication administration information. Clinical record review revealed that Resident 16 had diagnoses that included hypertension (high blood pressure), heart failure, anemia (blood disorder), and kidney disease. On July 18, 2025, the physician ordered staff to administer a blood pressure medicine (hydralazine HCl) twice a day and once at bedtime. Staff was not to administer the medication if the resident's systolic blood	F 0684		

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F 0684 SS=D	Continued from page 12 pressure (the first measurement of blood pressure when the heart beats and the pressure is at its highest) was less than 100 millimeters of mercury (mmHg). Review of Resident 16's July 2025 Medication Administration Record revealed that staff administered the medication 28 out of 29 times with no documented evidence that the blood pressure was assessed prior to medication administration per the physician's order. Clinical record review revealed that Resident 1 was admitted to the facility on July 14, 2025, with diagnoses that included hypertension (high blood pressure), atrial fibrillation (irregular heartbeat), and dysphagia (difficulty swallowing). On July 14, 2025, the physician ordered for staff to obtain the resident's weight daily. There was no documented evidence that staff obtained Resident 1's weight on July 16, 18, 25, or 26, 2025. In an interview on July 28, 2025, at 4:15 p.m., the Director of Nursing confirmed there was no documented evidence Resident 16's blood pressure	F 0684		

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F 0684 SS=D	Continued from page 13 was taken prior to medication administration, and that Resident's 1's weight was taken daily as per physician's order. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0684		
F 0814 SS=C		F 0814		

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F 0814 SS=C	Continued from page 14 483.60(i)(4) Dispose Garbage and Refuse Properly §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by:	F 0814	Based on observation during a Jul 28, 2025 survey tour, it was determined that the facility failed to dispose of trash and refuse properly. 1. The facility staff disposed of the trash and refuse immediately after the surveyor made the leadership team aware of the alleged deficiency on July 28, 2025. 2. No residents were affected by this alleged deficient practice. An initial audit was completed by the Facility Administrator or designee on Jul 28, 2025 3. Re-education was provided to the facility leadership staff, the Dietary Department, Maintenance Department and the Housekeeping department. The facility will conduct audits to ensure trash and refuse is disposed of properly. 4. The Facility administrator will conduct random weekly audits for 3 months. The Administrator will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. The Performance	Completion Date: **08/26/2025** Status: **APPROVED** Date: **08/18/2025**

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F 0814 SS=C	Continued from page 15 Based on observation, it was determined that the facility failed to dispose of trash and refuse properly. Findings include: Observation of the dumpster area on July 28, 2025, at 10:30 a.m., revealed three full trash bags outside the dumpster and a used disposable glove on the ground. The top lid of the garbage dumpster was open and it was full of trash bags. 28 Pa Code 201.18(b)(3) Management.	F 0814	Improvement Committee will evaluate and determine the effectiveness of the plan to ensure compliance is achieved and determine if further monitoring and evaluation is required. Date of Compliance: 08/26/2025	

Certified End Page

HUNTINGDON SKILLED NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 053802

SURVEY EXIT DATE: 07/28/2025

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