STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395597	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pickering Manor Home	226 North Lincoln Ave Newtown, PA 18940

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on clinical record review and staff interview, it was determined that the facility failed to implement physician's orders for one of 13 sampled residents. (Resident 1)Findings include: Clinical record review revealed that Resident 1 had diagnoses that included congestive heart failure, atrial fibrillation, and hypertension. A physician's order dated July 1, 2025, directed staff to weigh the resident daily and to notify the physician if there was a two to three pound (lb.) gain in 24 hours or a five pound gain in a week. A review of the care plan indicated that Resident 1 was at risk for fluid overload due to congestive heart failure. A review of weight documentation between August 17, 2025, and September 17,2025 revealed that there was no evidence that staff weighed Resident 1 as ordered on August 21, 25, and 27, 2025, and on September 3, 5, 8, and 15, 2025. Resident 1 had a 7.5 lb. weight gain on August 19, 2025, and a three lb. weight gain on September 2 and 11, 2025. There was no documented evidence that staff notified the physician of the weight gain. In an interview on September 18, 2025, at 11:20 a.m., the Director of Nursing confirmed that there was no documented evidence that staff attempted to weigh the resident as ordered. In an interview on September 18, 2025, at 11:35 a.m., the Assistant Nursing Home Administrator confirmed that there was no documented evidence that staff notified the physician of the weight gain. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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	395597	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pickering Manor Home	226 North Lincoln Ave Newtown, PA 18940

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and review of facility documentation it was determined that the facility failed to ensure that staff provided adequate supervision and assistance in order to prevent repeated falls for one of four sampled residents who were at risk for falls. (Resident 42)Findings includeClinical record review revealed that Resident 42 was admitted to the facility on [DATE], and had diagnoses that included supranuclear palsy, (neuro-degenerate disease involving a gradual deterioration of the brain), Parkinson's disease, cognitive communication deficit, anxiety, difficulty walking and unsteadiness on her feet. The Minimum Data Set assessment dated [DATE], indicated that the resident had some cognitive impairment, was dependent for toileting and had two or more falls since admission. A review of the care plan revealed that the resident was at risk for falls due to supranuclear palsy, Parkinson's disease and impaired mobility. There was an intervention dated June 2, 2025, for staff to assist and maintain one to one surveillance in the bathroom with the resident. Review of nursing notes and facility documentation revealed that Resident 42 fell a total of 26 times between May 9, 2025, through September 6, 2025. Twenty one of the falls were unwitnessed by staff and six of the falls were witnessed by staff. Twelve of the falls occurred in or near the bathroom, four of the falls were out of bed and two of the falls were out of her wheelchair. On May 11, 2025, a nurse noted that the resident was non-compliant with using the call bell and she was getting out of the wheelchair without assistance. The nurse also noted that the resident had been trying to get out of bed multiple times by herself. On May 12, 2025, at 10:38 a.m., a nurse noted that the resident was lowered to the floor by staff. On May 13, 2025, at 10:10 a.m., a nurse noted that staff witnessed the resident fall to her knees when she had attempted to stand after toileting. Review of facility documentation revealed that on May 13, 2025 at 7:33 p.m. , the resident fell in the bathroom. On May 19, 2025, at 9:30 a.m., the resident had a fall in her bedroom. The facility investigation indicated that the resident stated she fell trying to transfer from the wheelchair to her bed. On June 1, 2025, at 9:30 a.m., an aide found her on the floor in her bathroom. Facility documentation dated June 9, 2025, at 1:34 p.m., indicated that the resident had an unwitnessed fall. She was found kneeling in front of her bathroom. On June 12, 2025, at 8:28 a.m., the resident had an unwitnessed fall in her bathroom. The facility investigation indicated that the resident had poor safety awareness, weakness and an unsteady gait. On June 19, 2025 at 1:30 p.m., the resident had an unwitnessed fall out of bed. She had tried to get up out of bed on her own into her wheelchair and fell. The facility investigation indicated that the resident had been agitated and restless and that she tended to get up out of bed by herself. On June 20, 2025, at 2:03 a.m., the resident had another unwitnessed fall out of bed. The facility investigation indicated that the resident had been confused prior to the fall. On July 7, 2025, at 4:45 p.m., the resident had an unwitnessed fall and was found on the floor in her room. On July 16, 2025, at 6:22 p.m., the resident had another unwitnessed fall in her room and had slid from her wheelchair. On July 17, 2025, at 8:30 a.m., she had an unwitnessed fall in the bathroom and again on July 22, 2025, at 9:16 a.m., she was again found on the floor in her bathroom. On July 23, 2025, at 2:56 p.m., the resident had a witnessed fall when an aide was taking her to the bathroom. The investigation indicated that the resident had leaned forward and fallen out of her wheelchair in the bathroom. On July 24, 2025, at 2:56 p.m., the resident had an unwitnessed fall in her bathroom. On July 27, 2025, at 5:42 p.m., she had a witnessed fall in her bathroom when she had leaned forward off of the toilet. On July 29, 2025, at 1:39 p.m., an aide took the resident to the bathroom and she fell when she leaned forward on the toilet. On July 30, 2025, the resident had two unwitnessed falls. At 8:01 p.m. , she fell in the bathroom and at 9:37 p.m., she had a fall in her room and was found next to her bed. On August 13, 2025, at 1:46 p.m., on August 18, 2025, at 10:27 p.m., and again on August 30, 2025, at 9:30 p.m. , the resident fell and the facility investigation indicated that she had been in bed prior to the falls.On September 2, 2025, at 6:33 p.m., an aide had taken the resident to the bathroom. The facility investigation further indicated that the aide had transferred her to the toilet and stepped away. When the aide returned to the bathroom to reposition the resident to her wheelchair she noticed the resident standing on her own. She lost her balance and fell onto the shower bench. On September 3, 2025, at 9:25 a.m., the resident again fell in her bathroom. The investigation indicated that the resident had got up on her own, got back to her wheelchair and was trying to get into bed. The resident told the aide that she had fallen when she was going to the bathroom. On September 6, 2025, at 8:00 a.m., the resident had an unwitnessed fall out of bed. The resident stated at this time that she had wanted to get up out of bed. There was no documented evidence