

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/23/2025
NAME OF PROVIDER OR SUPPLIER  Aristacare at Meadow Springs		STREET ADDRESS, CITY, STATE, ZIP CODE  845 Germantown Pike Plymouth Meeting, PA 19462	

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)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43923</p> <p>Based on review of clinical records and observations, as well as resident and staff interviews, it was determined that the facility failed to ensure that care plan was updated to reflect changes in care needs for one of six residents reviewed (Resident R1).</p> <p>Findings include:</p> <p>A review of the facility policy titled Ongoing Care Plan Updates dated November 2028 revealed To develop a comprehensive care plan is developed that incorporates the resident's goals, preference, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.</p> <p>A review of the clinical file revealed that Resident R1 was admitted to the facility on [DATE]. Further examination of Resident R1's Minimum Data Set (MDS), dated [DATE], indicated that the Brief Interview for Mental Status (BIMS) was not recorded. This omission suggests that the resident was unable to participate in the assessment due to severe cognitive impairment.</p> <p>A review of the clinical progress notes dated January 7, 2025, revealed that facility received a call from the local hospital where Resident R1 was discharge from that the AFB Sputum Culture obtained on December 4, 2024, Tuberculosis testing, returned with a positive result. Facility isolated Resident R1 for airborne precautions. Notified the county's Department of Health, received recommendations, notified the Resident R1's family and physician.</p> <p>A review of Resident R1's comprehensive care plan, dated December 30, 2024, revealed no revisions addressing the resident's new tuberculosis diagnosis. No interventions or specific care plan were developed to address the tuberculosis diagnosis.</p> <p>An interview with the Director of Nursing (Employee E2) on January 23, 2025, at 12:45 p.m. confirmed that Resident R1's care plan had not been updated to reflect the tuberculosis diagnosis or to include any special interventions related to care and isolation requirements.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>

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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