STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395019	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Meadow Springs	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.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 46106 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident and resident representative receive written notice of the facility bed-hold policy at the time of a facility-initiated transfer to a hospital for one of 28 residents reviewed for hospitalization . (Resident R100) Findings include: Review of nursing note for Resident R100, dated February 17, 2025, revealed that Resident R100 was transferred to hospital emergency room for low hemoglobin levels. Further review of Resident R100's clinical record revealed that there was no documented evidence that the resident and his representative were provided with a written notice of the facility bed-hold policy at the time of Resident R100's facility-initiated transfer to the hospital. Interview with the Nursing Home Administrator, Employee E1, on February 27, 2025, at 3:24 p.m. that Resident R100 and his representative were not provided with the bed hold policy, that included information explaining the duration of the bed-hold, bed hold reserve payment and permitting return to a bed at the facility. Further interview confirmed that there was no system in place to ensure that the resident and resident representative receive written notice of the facility bed-hold policy at the time of a facility-initiated transfer to a hospital. 28 Pa Code 201.14(a) Responsibility of licensee 28 PA Code 201.29(f) Resident rights

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

Printed: 04/30/2025
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No. 0938-0391

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 02/27/2025
NAME OF PROVIDER OR SUPPLIER Aristacare at Meadow Springs		STREET ADDRESS, CITY, STATE, ZIP CODE 845 Germantown Pike Plymouth Meeting, PA 19462	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06525 Based on clinical record review,and review of policies and procedures, it was determined that the facility failed to update and revise a resident care plan realted to a wrist fracture for one of three residents reviewed. (Resident R85) Findings include: A review of the undated facility policy titled ongoing care plan updates revealed that it was the responsibility of the facility to develop and update the comprehensive care plan to include resident's goals, preferences, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. Clinical record review revealed a quarterly assessment dated [DATE] indicated that this resident was severely cognitively impaired. The assessment indicated that Resident R85 had impaired upper and lower extremities. The assessment also indicated that Resident R85 was totally dependent on staff for rolling left to right and chair to bed/bed to chair transfers. Clinical record revealed that this resident was diagnosed with a left wrist dislocation on September 19, 2024. The orthopedic physician decided to treat the resident with immobilization instead of surgery. The orthopedic physician advised the staff at the facility to use caution when performing transfers with resident R85. Clinical record review revealed that Resident R85's care plan had not been updated or revised post incident dated September 19, 2024, to include using caution with the left wrist when performing transfers. 28 PA Code 211.10(a)(b)(c)(d) Resident care policies 28 PA Code 211.12(c)(d)(1)(3) Nursing services

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 06525 Based on observations, and interviews with staff, it was determined that the facility failed to provide appropriate treatment and services with a resident who exhibited a contracture of the hand for one of seven residents reviewed s. (Resident R85) Findings include: A review of the undated policy titled activities of daily living revealed that the facility was responsible for ensuring that residents receive assistance as needed for bathing, showering, dressing, grooming, betting out of bed, walking toileting and eating. The policy also indicated that special equipment would be provided as need for each resident. The policy said that the resident's care plan would reflect the appropriate level of care and personal preferences of each resident for activities of daily living. Clinical record review for Resident R85 revealed a quarterly Minimum Date Set (MDS- assessment of resident care needs) dated September 8, 2024 that indicated that Resident R85 had functional impairments of the upper and lower extremities. The assessment also indicated that this resident was fully dependent on staff for showering, bathing,and personal hygiene. This assessment indicated that Resident R85 was at risk for pressure sore development. Observations of Resident R85 at 11:00a.m., on February 25, 2025 with licensed nurse, Employee 12 revealed that this resident had contracted upper extremities. The resident was observed sitting in a geriatric chair at the bedside with long soiled fingernails. Further exam of the palms and fingers of Resident R85's hands revealed reddened palms that contained peeling and flaking skin. Interview with the physical therapist, Employee E5 at 9:30 a.m., on February 27, 2025 confirmed that Resident R85 was an appropriate candidate for right upper and left upper extremity adapted equipment (palm guards and lambs wool) to prevent skin breakdown and assist with further contracture development. 28 PA. Code 211.10(a)(b)(c)(d) Resident care policies 28 PA. Code 211.12(c)(d)(1)(3) Nursing services

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06525 Based on observations of care and services, clinical record review, interview with staff, and reviews of policies and procedures, it was determined that the facility failed to ensure that for one of two residents reviewed with enteral nutrition that appropriate and timely treatment, to prevent complications of gastrojejunostomy tube feeding was implemented. (Resident R65) Findings include: A review of the undated policy titled Enteral Nutrition revealed that adequate nutritional support would be provided to residents that were unable to consume adequate nutritional intake by mouth. The policy indicated that enteral feeding orders would be written to ensure consistent volume infusion. The policy indicated that the dietitian was responsible for assessment of the gastrostomy or jejunostomy (surgical creation of an opening (stoma) through the skin at the front of the abdomen and the wall of the jejunum (part of the small intestine).tube feeding) with the nurse. Clinical record review for Resident R65 revealed a comprehensive assessment MDS (an assessment of care needs) dated November 19, 2024 that indicated this resident was was severely cognitively impaired. The nutrional and swallowing assessment indicated that this resident had a tube feeding. Clinical record review for Resident R65 revealed that the nurse practitoner had assessed this resident on January 10, 2025 and documented that the resident had to have his tube feeding replaced for dislogement for the second time this week. The nurse practitioner indicated in this note that the tube feeding insertion site or ostomy was slightly worn and stretched. The care plan was to have Resident R65 evaluated by a gastrointestinal [NAME] for a different insertion site Clinical record review indicated that Resident R65 was experiencing complications with his gastrojejuno tube feeding. The nurse practitioner documented on January 27, 2025 that Resident R65 was being assessed at the request of the nursing staff for a leaking gastrojejunostomy tube feeding. The nurse practitioner's progress note indicated that Resident R65 had to have his tube feeding replaced twice in the past two weeks. The plan of care according to the nurse practitioner was to have the resident evaluated by a gastrointestional physician on February 3, 2025 to explore a different insertion site for the tube feeding for Resident R65. Clinical record review for Resident R45 revealed that the resident did not receive a gastrointestional examination on February 3, 2025 as care planned. The nursing progress note on February 25, 2025 indicated that the resident was sent to the hospital from the gastrointestional physician's consultation for surgical treatment of the tuge feeding site. Clinical record review revealed physician's orders for February, 2025 to cleanse the gastrojejuno tube feeding site with soap and water and apply barrier cream topically and cover with a drainage sponge every shift. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with the director of nursing at 1:00 p.m., on February 25, 2025 confirmed that Resident R65 gastrointestional consultation that was ordered to be completed on February 3, 2025, was not done timely and according to physican's orders. 28 PA. Code 211.10(c) Resident care policies 28 PA. Code 211.12(d)(1)Nursing services

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46106 Based on review of clinical records, staff and resident interviews, it was determined that the facility failed to provide culturally competent, trauma informed care in accordance with professional standards of practice, accounting for the resident's past experiences and preferences in order to eliminate and/or mitigate triggers that may cause re-traumatization of the resident for one of 28 residents sampled (Resident R 27) Findings include: A review of the clinical record revealed that Resident R27 was admitted to the facility on [DATE], with diagnoses to anxiety disorder, and post-traumatic stress disorder (PTSD) Interviewed with Social worker, Employee E15 on February 26, 2025, at 2:10, revealed that the resident R27's PTSD triggers is unknown by facility. Resident R27's current care plan on February 24, 2025, revealed a care plan for PTSD. Further review of the care plan did not address resident's actual diagnoses/condition of PTSD, identifying the resident's past experiences and possible triggers that may cause re-traumatization. Interview with the Social worker, Employee E15, on January 26, 2025, at 2:26 PM. confirmed that Resident R27 plan of care for PTSD did not include resident's actual diagnoses/condition of PTSD, identifying the resident's past experiences and possible triggers that may cause re-traumatization. 28 Pa. Code 211.12(c)(d)(3)(5) Nursing services

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 06525 Based on clinical record reviews, interviews with staff and policies and procedure reviews, it was determined that the facility failed to ensure that one of six residents reviewed was being monitored and assesed for continued use of psychotropic medication. (Resident R19) Finding include: A review of the undated policy titled psychotropic medication revealed that it was the responsibility of the facility to ensure that psychotropic medications were being monitored and used properly. According to the policy psychotropic medications were drugs that effect brain activity with mental processing and behaviors. The policy indicated that as needed psychotropic medications were limited to fourteen days. The policy also indicated that if the prescriber wanted the as needed medication to be extended then the reason must be documented in the medical record and the duration of the as needed medication must also be indicated in the order for the psychotropic medication. Clinical record review for Resident R19 revealed a quarterly Minimun Data Set (MDS-an assessment of care needs) dated January 13, 2025 indicated this resident was cognitively intact and had diagnoses that included: seizure disorder and depression. The assessment also indicated the resident was receiving antidepressant and hyponotic mediations. Clinical record review revealed a physician's order dated December 4, 2024 for the medication Hydroxyzine HCL (an antihistamine) 25 milligrams (mg) every eight hours as needed for anxiety. Clinical record review revealed a psychatrist progress note dated February 10, 2025 that indicated Resident R19 had a diagnosis of dementia, insomnia and anxiety. The psychiatrist indicated that the resident reported that she was not anxious; however she reported being sad due to missing her family. Clinical record review revealed no documentation to indicate that the physician had ordered this as needed medication that was being used to treat symptoms of anxiety for a limited time of fourteen days. There was also no documentation to indicate that the physician indicated the rationale for the continued use and specific duration for the extended use of the medication Hydroxyzine HCL. Interview with the registered nurse, Employee E18 at 1:00 p.m., on February 27, 2025 confirmed confirmed that there was no documentation to indicated that the physician had ordered Hydroxyzine HCL for a limited 14 day time period. The registerd nurse also confirmed that there was no documentation to indicated that the physician was listing a rationale for the extended use of the Hydroxyzine HCL or the duration at which the physician planned to use this medication for Resident R19. 28 PA Code 211.5(f)(vii) Medical records 28 PA. Code 211.12(d)(1) Nursing services

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 06525 Based on observations of the food and nutrition services department, interviews with staff, it was determined that essential food service equipment and mechanical devices were not operating efficiently and effectively in the main kitchen. Findings include: Observations of the three compartment sink on February 24, 2025 revealed that the sink compartment used to sanitize the pots, pans, utencils, trays and cooking equipment was not holding water and the sanitizing solution. When tested the water and chemical were not at the proper concentration, according to the manufacturers recommendations. Upon further investigation the piping mechanism underneath the sinks were leaking water onto the floor. Interview with the Director of Dietary Services, Employee E13, on February 26, 2025 confirmed that this sink bay did not have the commercial sink drain and stopper to hold the chemical sanitizer and water concentration to effectively sanitize the pots, pans, utencils, trays and cooking equipment. Observations on February 24, 2025 of the metal doors leading directly from the main kitchen, to outside the building onto the loading and receiving dock, revealed that these doors were not sealing completely upon closing. Upon closing the doors a one inch open space was noted at the threshold of the doors. The essential mechanical door sweep for this exterior door was missing, allowing easy access for pest and rodents. Observations of the dry food storage area located in the main kitchen revealed rodent droppings on the floor underneath the large metal shelving being used for food storage. 28 PA. Code 201.18(e)(1)(2.1) Management