STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395134	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inglis House	2600 Belmont Avenue Philadelphia, PA 19131

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923 Based on the review of facility documentation, clinical records, hospital records, and interviews with resident and staff, it was determined the facility failed to provide appropriate staff supervision for Resident R1. This failure resulted in actual harm to Resident R1 who was found with a vertical laceration beginning at the midline of the forehead extending towards the scalp for one of 7 residents reviewed. (Resident R1) Findings include: Review of the facility policy titled Resident Safety revised on September 22, 2016, revealed nurse aides will make safety/hygiene rounds on all resident to ensure that the environment is safe and that resident hygiene needs are met. It is recommended that rounds be made every 2-3 hours. Continued review of policy revealed under bullet number 8 indicates Provide two or more person assist when necessary during transfer to ensure staff and resident safety. Further review of facility policy revealed under Care Plan Documentation section indicated, Assistive devices, safety measures, amount of assistance required by the resident to be documented in the approach/interventions section of the plan of care. Review of Resident R1's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses of laceration without foresight body of unspecified part of head, Epilepsy (seizures), Neurogenic Bowel (dysfunctional of the bowel), Neuromuscular Dysfunction of bladder, restless legs syndrome, legal blindness, Paraplegia (paralysis that effects lower held of the body). Review of Resident R1's quarterly Minimum Data Set assessment (MDS- periodic assessment of resident care needs) dated February 11, 2025, revealed the resident had a BIMS (Brief Interview of Mental Status) score of 13, indicating the resident was cognitively intact. Continued review of the MDS assessment revealed the resident's functional abilities for self-care task such as toileting hygiene, shower/bathe, dressing, personal hygiene, bed mobility is dependent. Dependent definition based on the MDS coding indicates Helper does all the effort. Resident does none of the effort to complete the ability. Or the assistance of 2 or more helpers is required for the resident to complete the activity. Review of the comprehensive care plan dated, March 1, 2025, identified a goal and intervention of February 2, 2025, for bed mobility - resident requires assistance by (2) staff to turn and reposition in bed frequently and for dressing- the resident requires assistance by (2) staff to dress. (continued on next page)

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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NAME OF PROVIDER OR SUPPLIER Inglis House		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 Belmont Avenue Philadelphia, PA 19131	

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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 - Actual harm Residents Affected - Few	Review of information submitted to the State Survey Office on March 19, 2025, revealed Resident R1 was care planned for 1 assist for bed personal hygiene. When the nurse aide was providing morning care, while bathing the resident in bed Resident R1 was holding onto the bed rail to assist the nurse aide with washing the resident's back. The bed rail fell (disengaged) then Resident R1 fell from the bed to the floor. Resident R1 was assessed with laceration to the forehead, the resident was transferred to ER (emergency room) by 911 (Emergency Medical Services). The physician and resident's spouse were both notified. Bed rails were immediately checked by the engineer, both rails were found functioning. Review of the facility's investigation completed March 19, 2025, revealed a written statement from Nurse Aide, Employee E10, which indicated, I went into resident's room approximately 8:00 a.m. I washed the front of the resident. I was standing on the left, side rail were up locked on the right side of the bed. I then dressed [resident] and put the brief halfway on. I then pulled the side rails on left side up and I heard the rails click (locked) I went to [his/her] right side locked the bed and turned resident to the left (toward the sink) as I was pulling out brief, I hear a click, and the rails went down, and the resident fell to the floor on [his/her] stomach. I immediately yelled for help multiple staff members came in to assist. Review of Resident R1's nursing documentation dated March 19, 2025 revealed called to resident room at 8:15 am, resident found on the floor lying on abdomen . talking and crying, opening to mid forehead with large amount of bleeding noted. Resident stated 'my arm hurts,' airway secure, non labored breathing, head stabilized, pressure applied to open area on forehead MD (physician) called order to send to [hospital] for evaluation given, 911 (Emergency Medical Services) called. Resident remains in position on floor until 911 arrived, [resident] continued to talk, no cognitive decline noted, charged nurse and respiratory therapist remained with resident . 911 arrived at 8:43 am wish (with) 2 attendants, resident let facility via stretcher at 8:46am. Review of Resident R1's hospital after-visit summary, dated March 19, 2025, revealed Large left scalp hematoma. Assessment further revealed, a 10cm (centimeters) vertical laceration beginning at the midline of the forehead extending towards the scalp resulting in exposure of the front bone face showing no fractures of the calvarium or skull base. Review of Resident R1's nursing progress note dated March 19, 2025, revealed, Resident R1 returned to the facility at 9:30 p.m. from the medical center. Resident presented with 35-40 stitches from the scalp to her forehead and covered with gauze, no drainage noted, resident denies pain at this time, slight bruising noted. Resident mode was stable and pleasant, alert to person, time and place. Review of Resident R1's therapy progress notes, dated March 20, 2025, revealed Occupational Therapy (OT) evaluation provided following return from hospital s/p (status post) fall from bed. Resident is currently in hill-rom (hospital) bed with bilateral (b/l) full rails and meridian low air loss mattress. Rails are used both for bed mobility and for safety secondary to diagnoses of MS (multiple sclerosis) paraplegia, and seizure disorder. OT reviewed event with resident. (She/he) reports that (she/he) was turned on her/his side and received care and does not recall what happened when (she/he) accidentally fell . Reviewed bed positioning and mobility with resident. (She/he) is agreeable to a wide bed which would allow for more space for lateral turning and repositioning. Currently discussing potential room change to a large room with ceiling lift that would better accommodate a wide bed. (continued on next page)

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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 - Actual harm Residents Affected - Few	Review of Resident R1's wound progress notes dated March 20, 2025, revealed, Resident was assessed for injury to forehead extending to front portion of scalp. Area is fully approximately with about 39 stitches. Observation conducted on April 3, 2025, at 9:41 a.m., of Resident R1, who was lying in a hospital gown in bed, ready to receive morning care from nurse aide, Employee E4. No other staff were accompanying Employee E4 at that time. At 9:48 a.m., Employee E4 exited the room after providing care and reported needing a second nurse aide to assist with a Hoyer lift (mechanical device used for transfer of resident from one surface to another) transfer, meaning the resident needed to be transferred from the bed to a wheelchair, requiring an additional person. Employee E4 then returned to the room to hook up the Hoyer pad to the lift, which had already been placed under the resident's back. Continued observation on April 3, 2025 at 9:57 a.m., revealed a second nurse aide, Employee E5, entered the room to assist nurse aide, Employee E4 in transferring Resident R1. At 10:00 a.m., Employees E4 and E5 came out and was interviewed. Employee E5 confirmed the aides strapped, guided, and transferred Resident R1 from the bed into the wheelchair. Employee E4 confirmed, they did not provide support with dressing, turning, changing, or washing Resident R1, and further clarified, I only strapped, guided, and transferred R1 over into [his/her] wheelchair. Once Employee E4 completed providing care to Resident R1, interview was conducted at 10:01 a.m. on the same day. During the interview, it was revealed that Employee E4, working alone, had changed the resident by turning [him/her] from right side to left, cleaning resident's right-side buttock, placing a brief, and then repeating the procedure on the left side. Employee E4 asked Resident R1 to hold onto the railing while turning resident to each side to clean the buttock, place a brief and placed a Hoyer lift pad under Resident R1. When asked if Employee E4 was aware of how many people were needed to assist with turning and repositioning, Employee E4 confirmed, 2 people assist, but we're short right now, and further revealed, he was the only one providing morning care to Resident R1 before transferring resident to [his/her] wheelchair with the assistance of Employee E5. Interview conducted On April 3, 2025, at 10:16 a.m., with Resident R1, who was observed with a laceration on his/her forehead and hair shaved. Resident R1 reported that after the incident, there was a lot of blood in my hair, and they had to shave my hair, and I ended up with 38 stitches. Resident R1 further revealed, today, he/she received care from Employee E4, who asked Resident R1 to hold onto the railing while turning resident to provide care. Interview attempted on April 2, 2025, at 10:45 a.m. with nurse aide, Employee E10 who was on medical and family leave as of April 1, 2025, but was not able to be contacted. Interview conducted on April 2, 2025, at 11:03 a.m., with the Rehabilitation Director, Employee E6. Employee E6 confirmed that Resident R1 was in an appropriate bed with bilateral railings, which were assessed based on the resident's weight. The railings were re-assessed and found to be functioning properly. Additionally, Resident R1 was re-assessed, and interventions, such as providing a larger bed to offer more space, were implemented. A bed mobility assessment was conducted, which recommended, 2 person assistance with bed mobility, dressing, turning, and repositioning. A request was made to provide the rehabilitation assessment conducted prior to the fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On April 2, 2025, at 11:56 an interview was conducted with nursing assistant, Employee E7 who reported the way she would know which resident requires 1 or 2-person assist is based on the assignment sheet. Reviewed assignment sheets but failed to identify notation that South 1 Nursing unit had anyone requiring 2 person assistance. On April 2, 2025, at 12:32 p.m., an interview was conducted with the Assistant Director of Nursing, Employee E2. Employee E2 confirmed, the comprehensive care plan, last updated on March 1, 2025, which was prior to the fall, identified an intervention from February 2, 2025. The care plan indicated for bed mobility, Resident R1 requires assistance from 2 staff members to turn and reposition frequently, and for dressing, the resident requires assistance from 2 staff members to dress. On April 2, 2025, at 12:59 p.m., an interview was conducted with the Administrator, Employee E1, and the Assistant Director of Nursing, Employee E2. Staff confirmed, according to the comprehensive care plan and MDS assessment dated [DATE], Resident R1 requires 2-person assistance for bed mobility, turning, repositioning, and dressing. However, it was also reported that staff continued to provide only 1-person assistance, as observed during today's evaluation. On April 2, 2025, at 2:00 p.m., the Rehabilitation Director, Employee E6, presented documentation that included two Rehab Screenings, which were conducted every 90 days. It was noted that during the February 14, 2025, screening for Resident R1, the assessment indicated, 1 person assist was required for dressing, but no documentation was made regarding the number of people needed for bed mobility, which is a required detail. A previous Rehab Screening, conducted on November 1, 2024, documented 1-person assistance was needed for both bed mobility and dressing. However, this information was not reflected in Resident R1's care plan and contradicted the MDS assessment dated [DATE]. Employee E6 acknowledged, she signs off on care plan revisions but was unable to provide an explanation as to why Resident R1's care plan was not updated accordingly. On April 2, 2025, at 2:15 p.m., an interview was conducted with the Assistant Director of Nursing, Employee E2, regarding nurse aides' knowledge of which residents require a 1-person assist versus a 2-person assist. Employee E2 reported that, according to the nurse aides' task documentation, it was revealed the nurse aides had been documenting providing 1-person assist to Resident R1 both before and after the incident. The facility failed to provide appropriate staff assistance during morning care to Resident R1 which resulted in actual harm to Resident R1 who sustained a fall and was found with a vertical laceration beginning at the midline of the forehead and extending toward the scalp. This injury exposed the frontal bone and required 35-40 stitches to close the wound. 28 Pa. Code 201.18(e)(1) Management 28 Pa Code 211.10(d) Resident care policies 28 Pa. Code 211.12 (c)(d)(1) Nursing Services

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923 Based on review of clinical record, faciltiy documentation, facility policy, and staff interviews it was determined the facility failed to ensure there was a sufficient number of nursing staff available to provide care for one of seven residents reviewed. (Resident R1) Findings include: Review of the facility policy titled, Resident Safety revised on September 22, 2016; revealed nurse aides will make safety/hygiene rounds on all resident to ensure that the environment is safe and that resident hygiene needs are met. It is recommended that rounds be made every 2-3 hours. Continued review of policy revealed under bullet number 8 indicates Provide two or more person assist when necessary during transfer to ensure staff and resident safety. Further review of facility policy revealed under Care Plan Documentation section indicated, Assistive devices, safety measures, amount of assistance required by the resident to be documented in the approach/interventions section of the plan of care. Review of Resident R1's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses of laceration without foresight body of unspecified part of head, Epilepsy (seizures), Neurogenic Bowel (dysfunctional of the bowel), Neuromuscular Dysfunction of bladder, restless legs syndrome, legal blindness, Paraplegia (paralysis that effects lower held of the body). Review of Resident R1's quarterly Minimum Data Set assessment (MDS- periodic assessment of resident care needs) dated February 11, 2025, revealed the resident had a BIMS (Brief Interview of Mental Status) score of 13, indicating the resident was cognitively intact. Continued review of the MDS assessment revealed the resident's functional abilities for self-care task such as toileting hygiene, shower/bathe, dressing, personal hygiene, bed mobility is dependent. Dependent definition based on the MDS coding indicates Helper does all the effort. Resident does none of the effort to complete the ability. Or the assistance of 2 or more helpers is required for the resident to complete the activity. Review of the comprehensive care plan dated, March 1, 2025, identified a goal and intervention of February 2, 2025, for bed mobility - resident requires assistance by (2) staff to turn and reposition in bed frequently and for dressing- the resident requires assistance by (2) staff to dress. Observation conducted on April 3, 2025, at 9:41 a.m., of Resident R1, who was lying in a hospital gown in bed, ready to receive morning care from nurse aide, Employee E4. No other staff were accompanying Employee E4 at that time. At 9:48 a.m., Employee E4 exited the room after providing care and reported needing a second nurse aide to assist with a Hoyer lift (mechanical device used for transfer of resident from one surface to another) transfer, meaning the resident needed to be transferred from the bed to a wheelchair, requiring an additional person. Employee E4 then returned to the room to hook up the Hoyer pad to the lift, which had already been placed under the resident's back. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued observation on April 3, 2025 at 9:57 a.m., revealed a second nurse aide, Employee E5, entered the room to assist nurse aide, Employee E4 in transferring Resident R1. At 10:00 a.m., Employees E4 and E5 came out and was interviewed. Employee E5 confirmed the aides strapped, guided, and transferred Resident R1 from the bed into the wheelchair. Employee E4 confirmed, they did not provide support with dressing, turning, changing, or washing Resident R1, and further clarified, I only strapped, guided, and transferred R1 over into [his/her] wheelchair. Interview conducted at 10:01 a.m. on April 3, 2025 after Employee E4 completed providing care to Resident R1. During the interview, it was revealed that Employee E4, working alone, had changed the resident by turning [him/her] from right side to left, cleaning resident's right-side buttock, placing a brief, and then repeating the procedure on the left side. Employee E4 asked Resident R1 to hold onto the railing while turning resident to each side to clean the buttock, place a brief and placed a Hoyer lift pad under Resident R1. When asked if Employee E4 was aware of how many people were needed to assist with turning and repositioning, Employee E4 confirmed, 2 people assist, but we're short right now, and further revealed, he was the only one providing morning care to Resident R1 before transferring resident to [his/her] wheelchair with the assistance of Employee E5. On April 2, 2025, at 12:59 p.m., an interview was conducted with the Administrator, Employee E1, and the Assistant Director of Nursing, Employee E2. Staff confirmed, according to the comprehensive care plan and MDS assessment dated [DATE], Resident R1 requires 2-person assistance for bed mobility, turning, repositioning, and dressing. However, it was also reported that staff continued to provide only 1-person assistance, as observed during today's evaluation. 28 Pa. Code 201.18(e)(1) Management 28 Pa Code 211.10(d) Resident care policies 28 Pa. Code 211.12 (c)(d)(1) Nursing Services