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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395134 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/11/2025 |
| NAME OF PROVIDER OR SUPPLIER Inglis House | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) |
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| <p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, and staff interviews, it was determined the facility failed to ensure that pain management was provided consistent with professional standards of practice, for one of 6 sampled residents (Resident R1). Findings include: A clinical record review revealed Resident R1 was admitted to the facility on [DATE], with diagnoses that include polyneuropathy (condition damaged to multiple peripheral nerves leading to pain, weakness and sensory loss), trigeminal neuralgia (condition causes intense pain similar to an electric shock on the side of the face), paraplegia (form of paralysis affects the lower body) and chronic pain. Resident R1's care plan, initiated on May 24, 2024, identified a goal for the resident to verbalize pain adequate relief of pain or ability to cope with incompletely relieved pain. The care plan included an intervention to administer routine pain medication regime as order. A physician's order for Resident R1 to be administered Lyrica 75 mg give 1 capsule by mouth two times a day for neuropathy hold for confusion or lethargy initiated on August 27, 2025 and discharged on September 9, 2025. On October 15, 2025 at 10:49 a. m. Resident R1 was interviewed and reported she had severe pain during in her upper body the evening shift on September 9, 2025. The doctor wanted to increase her Lyrica dose from 75 mg to 100 mg. The doctor stopped the 75 mg dose at 4:39 p.m. on September 9 and gave a new order for 100 mg at 9:00 a.m. the next day. Because of this, Resident R1 did not get her usual 5 p.m. Lyrica dose on September 9. On October 15, 2025, at 12:35 p.m., an interview with the Director of Nursing, Employee E1, revealed information from the September 2025 Medication Administration Report (MAR). The facility physician increases Resident R1's Lyrica dose from 75 mg to 100 mg. The physician discontinued the 75 mg order at 4:39 p.m. on September 9 and wrote a new order for 100 mg at 9:00 a.m. the next day. As a result, Resident R1 did not have a routine Lyrica order for the evening of September 9, 2025. It was further revealed, based on a written statement from the evening licensed nurse, Employee E7, dated September 9, 2025, that she reported this concern to the evening supervisor during medication administration, which took place between approximately 4 p.m. and 6 p.m. The statement further outlined: At around 9 p.m., Resident R1 approached me again and asked about her medication, expressing that she was in severe pain. I checked to see if the order was ready so I could administer it, but this time the order was not showing up at all. I then called the supervisor's office to speak. According to the Medication Administration Record (MAR), a Lyrica order for 100 mg was initiated on September 9, 2025, at 9:30 p.m. and was administered at 10:12 p.m. In the same interview, the Director of Nursing, Employee E1, confirmed that the Lyrica order was not administered on time. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (d)(1)(3)(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.

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