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	05/20/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on staff interviews, review of clinical records, and the review of facility documentation, it was determined that the facility failed to ensure that a resident received incontinence care in a timely manner for 1 out of 2 residents reviewed (Resident R1). Findings include: Review of the May 2026 physician's orders included the following diagnosis: multiple sclerosis (a neurological illness that can cause numbness, weakness, trouble walking, vision changes and other symptoms); cognitive communication deficit (occurs when a person struggles to communicate effectively due to underlying cognitive impairments such as attention, memory, executive function, or social cognition, rather than a primary language or speech disorder); intellectual disabilities (limitations in an individual's mental abilities that affect intelligence, learning and everyday life skills); muscle weakness; lack of coordination, and unsteadiness on feet. Review of the resident's person-centered plan of care with a revision date of May 25, 2026, included a plan of care for bowel and urine incontinence, and indicated that the resident needed disposable briefs, and needed to be changed prn (as needed). Continued review of the resident's person-centered plan of care indicated that the resident needed the assistance of 1 staff member to assist the resident with the activity of daily living related to toileting. Review of the resident's plan of care indicated that the resident required the use of a manual wheelchair. Review of the resident's Quarterly Minimum Data Set Assessment (MDS-a periodic assessment of a resident's need) dated February 24, 2026, indicated that the resident was awake, alert and oriented. Review of information submitted to the state survey agency on May 3, 2026, reported concerns with care and services that the resident needed during the 7:00 a.m. through the 3:00 p.m. nursing shift that were not provided by the facility in a timely manner on May 3, 2026. The concerns with care and services included concerns that the resident reported to a family member and was observed by the complainant during a video call with the resident sitting in urine-soaked clothing. The information submitted to the state survey agency also indicated that the above referenced incident was reported by resident/observed by the resident's member at 11:00 a.m. during their call, and at 11:45 a.m. both the complainant and the resident ended their video chat, and the complainant asked the resident to call her back once staff has changed her. Continued review of the information reported to the state survey agency indicated that the resident contacted the family member a 2nd time at 1:30 p.m. during her lunch meal and informed the complainant that she still had not been changed from when they spoke on the video chat earlier in the day. Review of the facility's investigation regarding the incident indicated that on May 4, 2025 at 1:20 p.m. the resident was interviewed by staff, but the interview documented indicated that (she/he) was not directly asked about the incident that occurred the day prior that was reported to the facility to rule out resident neglect. Review of the unsigned typed statement from the resident's friend (Resident R2) on May 6, 2026, at 1:00 p.m. documented that Resident R2 reported that the resident had an accident prior to or after arrival to (her/his) room, and that Resident R1 was at her doorway requesting assistance from staff for approximately 10-20 minutes. Resident R2 reported that staff eventually entered Resident R1's room Review of the undated statement regarding a complaint reported from the resident's assigned nurse aide (Employee E3) indicated that that resident was provided care to the resident in the morning, and that less than a half hour afterwards, the nurse aide stated that she received a (continued on next page)

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

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	05/20/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	message that the resident was wet. The nurse aide reported that she served the resident her lunch in her room, finished serving the other residents, collected resident trays after lunch, and then told Resident R1 that she was going to eat her lunch prior to changing her. Continued review of the nurse aide's statement documented that when the nurse aide was eating her lunch, a 2nd call came into the facility regarding concerns with Resident R1 needing assistance being changed. The nurse aide statement indicated that she stopped eating when she was notified of the 2nd call and went to provide incontinence care to the resident. During a discussion with the Nursing Home Administrator (NHA) and the Assistant Nursing at 12:01 p.m. the investigation was reviewed and it was discussed that the resident did not receive incontinence care in a timely manner It was discussed hat as the nurse aide was aware that the resident needed to be changed prior to the nurse aide serving the resident her lunch, prior to the nurse aide serving the other resident their lunch, prior to the nurse aide collecting lunch trays after the resident and other residents were done eating, and prior to the nurse aide eating her lunch. It was discussed that the nurse aide was notified again after a 2nd call came in when the nurse aide was eating her lunch, and that per the nurse aide's statement, it was not until this time that the nurse aide finally went to the resident's room to assist her with incontinence care. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

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	05/20/2026

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on staff interviews and observations, it was determined that the facility failed to ensure that resident call bells were within reach of them for 4 out of 5 residents observed (Resident R3, R4, R5, and R6). Findings include: During an observation on the 1 North nursing station, the following residents were observed in their rooms with call bells that were not within their reach. During an observation on May 14, 2026 at 3:17 p.m. Resident R3 was observed in the room lying in bed with the call bell hanging off the back of the bed where the resident could not reach the call bell. Licensed nurse (Employee E4) was present for this observation, picked the call bell up and placed it within the resident's reach. During an observation on May 14, 2026 at 3:20 p.m. Resident R4 was observed in their room lying in bed with the call bell on the floor, on the floor in the back of the bed. Licensed nurse (Employee E4) was present for this observation, picked the call bell up and placed it within the resident's reach. During an observation on May 14, 2026 at 3:25 p.m. Resident R5 was observed was observed in their room lying in bed with call bell hanging off the back of the bed, on the floor in the back of the bed. Licensed nurse (Employee E4) was present for this observation, picked the call bell up and placed it within the resident's reach. During an observation on May 14, 2026, at 3:26 p.m. Resident R6 was sitting in his wheelchair watching television. The resident's call bell was observed hanging from the right side of his bed (when walking in the room,) on the floor where the resident would not be able to retrieve it should had need to due to his physician impairments. During this time, the Nursing Home Administrator (NHA) was notified, and came into the resident room, picked the call bell up, and placed it within the resident's reach. During a discussion with the Nursing Home Administrator (NHA) on May 14, 2026, at 3:45 p.m. it was discussed concerns with the NHA regarding the residents not having their call bells within their reach during room observations on unit 1 north. 28 Pa. Code 211.12(d)(1) Nursing services