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	05/23/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508 Based on review of clinical records, review of facility policies, review of facility investigation, review of facility policies and staff interview, it was determined that the facility failed to ensure that residents were free from neglect for one of 35 residents reviewed (Resident R147). Findings include: (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy on abuse dated December 20, 2018, revealed that under section Purpose: To prohibit physical abuse, mental abuse, verbal abuse, sexual abuse, neglect, involuntary seclusion, deprivation of goods and/or services by staff, exploitation, and misappropriation of property for all residents. Under Section Policy number two, physical abuse, mental abuse, verbal abuse, sexual abuse, neglect, involuntary seclusion, deprivation of goods and or services by staff, exploitation and misappropriation of property will be prohibited. Residents will be free from physical abuse, mental abuse, verbal abuse, sexual abuse, neglect, corporal punishment and voluntary seclusions, deprivation of goods and or services by staff, exploitation and misappropriation of property. Residents will not be subjected to abuse by anyone, including but not limited to employees, other residents, consultants or volunteers, staff of other agencies serving the resident, resident representatives, family members and or legal guardians. Friends. For other individuals. #3. [NAME] House responds to suspected and alleged abuse of any type, neglect, involuntary seclusion, deprivation of goods and or services by staff, exploitation and misappropriation of property by following the seven components of abuse as identified by the Pennsylvania State Operations Manual, which provides the framework for organizational response for screening, training, prevention, identification, protection, and investigating and reporting abuse. #4. [NAME] House will thoroughly investigate all reports of suspected or alleged abuse, neglect and voluntary seclusion, deprivation of goods and or services by staff, exploitation and misappropriation of property, as well as all injuries of unknown origin to rule out potential abuse. Under section Definitions The following definitions should be applied when determining whether resident abuse or any type. Abuse is defined as the willful infliction of injury and reasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation of any individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Under section, Types of abuse include. #5. Neglect. The failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect occurs on an individual basis when a resident receives a lack of care in one or more areas. For example, absence of frequent monitoring for resident known to be incontinent. Resulting in being left to lie in urine or feces. A finding of neglect must be made if the accused individual demonstrates that such neglect was caused by factors beyond the control of the individual. Under section interpretation: Interpretation Neglect refers to failure through inattentiveness, carelessness, or omission to provide timely, consistent, safe, adequate, and appropriate services, treatment, and care. The absence of reasonable accommodation of individual needs and preferences may result in resident neglect. Review of Resident R147's clinical record revealed that Resident R147 was admitted to the facility on [DATE]. Resident R147's current diagnoses included Spastic Quadriplegic Cerebral Palsy (A permanent neuromuscular disorder causing limitation on all four limbs following a lesion on the developing brain.), Neurogenic Bladder (condition in people who lack bladder control due to a brain, spinal cord or nerve problems.), Mild Intellectual Disabilities, Urine Retention, Bipolar Disorder (in this order associated with episodes of mood swings ranging from depressive lows to manic highs.), Major Depressive Disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities causing significant impairment and daily life.), Quadriplegia (a symptom of paralysis that affects all of a person's limbs and body from the neck down.), Cognitive Communication Deficit, and Muscle Weakness. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R147's annual MDS (Minimum Data Set- a federally required resident assessment completed at a specific interval) dated July 10, 2023, section C0500 BIMS (brief interview for mental status) score revealed that Resident R147 scored 14 suggesting that Resident R147 was cognitively intact. Section G0110 (activities of daily living) revealed that Resident R147 was coded 3 for self-performance and 2 for support indicating that Resident R147 required extensive assistance in bed mobility with one person assist. Section G0400 (functional limitation in range of motion) revealed that resident was coded 2 both for upper and lower extremities indicating that resident had limitation in range of motion for both upper and both lower extremities. Section H0300 (urinary continence) was coded 3 indicating that Resident R147 was always continent (no episode of continent voiding). Section H0400 (bowel continent) was coded 3 indicating that Resident R147 was always incontinent (no episode of continent bowel movement). Review of Resident R147's nursing progress notes dated September 12, 2023, revealed that Nurse Supervisor, Employee E4, received electronic communication (e-mail) from Resident R147's sister regarding Resident R147 being left on the bedpan for an extended period of time on September 5, 2024. Resident R147 was initially unable to state exactly what had occurred when Employee E4 went to talk to Resident R147. Supervisor received an e-mail from Resident R147's sister on the morning of September 12, 2024, asking if Resident R147 told Employee E4 what happened to the resident last week. Employee E4 communciated to Resident R147's sister that Resident R147 did not come to her or ask to see her about anything that occurred with her. Employee E4 spoke with Resident R147 who then stated that one day last week her care nurse on 3-11 put her on the bed pan, but then she had to leave early. Resident R147 stated that when she was aware that she was still on the bed pan it was early in the am. Resident R147 skin was checked by supervisor for any skin breakdown when she was placed back into the bed in the afternoon to use the bedpan. Her skin was intact. No open areas or any red areas noted to her sacrum. Review of Employee E5's statement dated September 26, 2023, confirmed that nurse aide, Employee E5 put Resident R147 to bed at 9:30 p.m. and placed her on a bed pan and continued to do the rest of her assignment and when she finished her last person assigned to her, it was 10:55 p.m. Further Employee E5 revealed that resident R147 did not ring the bell. Employee E5 further confirmed in her statement that she forgot to go back to remove the bed pan from under Resident R147. Review of nurse aide, Employee E6 statement dated September 19, 2023, revealed that on September 5, 2023, she worked 11 to 7 shift and that Resident R147 was sleeping when she did her rounds. At around 4 to 4:30 a.m. she came into Resident R147 to put her on a bed pan when she found resident on a bed pan already. Employee E6 revealed that the previous shift did not inform her that Resident R147 was on a bed pan. Review of facility investigation of alleged abuse and neglect dated September 12, 2023, conducted by Employee E1 revealed that Resident R147 was interviewed and reported that she was placed on the bedpan at 9:00 p.m. and taken off bed pan at 4:00 a.m. Interview with Nursing Home Administrator, Employee E1conducted on May 21, 2024 at 1:49 p.m. confirmed that nurse aide, Employee E5 placed the bed pan under Resident R147 on September 5, 2023, at 9:30 p.m. and forgot that she placed a bed pan under Resident F147. Further Employee E1 also confirmed that nurse aide, Employee E5 left the facility at the end of her shift without removing the bed pan from under Resident R147. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further interview with Nursing Home Administrator, Employee E1 revealed that she did not substantiate the incident as neglect because, the incident was not willful. Employee E5 was out on a family leave of absence and was not contacted for an interview 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.18(b)(c) Management 28 Pa. Code 201.29 (c) Resident rights

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44882 Based on review of facility policy, clinical record review and interview with staff, it was determined that the facility did not ensure that a resident was free from misappropriation of property for one of 35 records reviewed (Resident R128). Findings include: Review of facility policy titled Abuse, Neglect and Exploitation Reporting and Investigation, most recent revision date December 20, 2018, revealed that the purpose of the policy was to prohibit .misappropriation of property for all residents. Further review revealed that misappropriation of resident property means the deliberate misplacement .or wrongful (temporary or permanent) use of a resident's belongings .without the resident's consent. Review of facility document titled In-service: misappropriation of items and goods, undated, revealed that package handling procedures include all domestic boxes/packages should be delivered to the designated pick-up locations, and security does not sign or hold packages for staff or residents behind the work post. Review of clinical record revealed that Resident R128 was admitted to the facility on [DATE], with diagnoses including, concussion and edema of cervical spinal cord (a traumatic swelling of the spinal cord in the neck, which can cause loss of function of the body below the point of injury), major depressive disorder and chronic pain due to trauma. Review of facility documents revealed that an investigation was initiated on January 29, 2024, in regard to Resident R128 reporting that an expected package from 'Walmart' had been confirmed delivered by 'Walmart', but that the resident had not received the items. Review of the investigation documents revealed photographic still images taken from a security video recorded on January 24, 2024. Review of the written investigation revealed that Security, Employees E4 and E5 were seen on camera with the resident's package behind the security desk. The employees opened the package and handled the contents. Further, Employee E4 was seen leaving the facility with the package. Interview with Employees E1, the Nursing Home Administrator, and E2, the Director of Nursing on May 23, 2024, at 1:00 p.m. confirmed that the package belonging to Resident R128 was inappropriately handled by Security, Employees E4 and E5 and was taken from the facility by Employee E4. 28 Pa Code 201.14 (a) Responsibility of license 28 Pa Code 201.18 (b) (1) Management

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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** 46993 Based on review of clinical records, observations, facility provided documentation and review of documentation from the Center of Disease and Control Prevention (CDC), it was determined that the facility did not ensure to develop and implement a care plan that includes measurable objectives, interventions and time frames for how staff will meet the residents' needs related to catheter care and enhanced barrier precautions for two of 35 residents reviewed (Residents R84 and R77) Findings include: Review of facility's policy titled 'Person-Centered Care Plan Process,' revised September 24, 2018, Identified problems are to be addressed on the care plan in the electronic medical record, per [NAME] policy and procedure guidelines. Observations on first floor unit, 1 North, on May 22, 2024 at 1:30 p.m. revealed a sign and supplies next to Resident R84's room and Resident R77's room for enhanced barrier precautions. In accordance with https://www.cdc.gov/hicpac/workgroup/EnhancedBarrierPrecautions.html, Enhanced Barrier Precautions (EBP) is an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission of S.aureus and MDROs . EBP may be applied (when Contact Precautions do not otherwise apply) to residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status Infection or colonization with an MDRO. 4. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE with hand hygiene products at the point of care. Review of R84's clinical record revealed medical history of urinary tract infection, infection and inflammatory reaction due to indwelling urethral catheter, breakdown (mechanical) of cystostomy catheter, neurogenic bowel, neuromuscular dysfunction of bladder. Review of Resident R84's current care plan revealed that the resident had a care plan for catheter care with interventions to use universal precautions. There was no evidence that the resident's care plan was updated to include Enhanced Barrier Precautions. Further review revealed that Resident R84 had a recent history of urinary tract infection's (UTI's) on April 29, 2024 and again on May 20, 2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R77's clinical records revealed medical history of neuromuscular dysfunction of bladder, neurogenic bowel, mixed incontinence, polyneuropathy, presence of urogenital implants. Further review of clinical records revealed presence of an indwelling urinary catheter and diagnosis of urinary track infection on April 7, 2024. Review of Resident R77's care plan revealed that there was no care plan developed for interventions related to catheter care. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(5) Nursing services

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44882 Based on clinical record review and interviews with staff, it was determined that the facility did not ensure that a resident was free from an excessive dose of pain medication for one of 35 records reviewed (Resident R165). Findings include: Review of clinical documentation revealed that Resident R165 was admitted to the facility on [DATE], with diagnoses of paraplegia (paralysis that affects all or part of the trunk, legs, and pelvic organs), acquired deformity of chest and rib, other psychoactive (affecting the function of the brain) substance abuse in remission, generalized anxiety disorder, and major depressive disorder. Review of nursing notes for Resident R165 revealed a note written by Licensed Nurse Practitioner Employee E6 on May 14, 2024, which stated, Fentanyl (a controlled narcotic pain medication which is applied via a patch placed on the skin for long acting delivery of the medication) 50 mcg [per hour patch] was unintentionally ordered and applied on 5/13/24, however patient made aware previous Fentanyl 12 mcg [per hour patch] will be resumed on 5/15/23. Review of the resident's medication order history revealed an order for Fentanyl Transdermal (through the skin) patch 72 hour 50 mcg/hr apply 1 patch transdermally every 72 hours was prescribed on May 10, 2024, and had been discontinued. An order for Fentanyl Transdermal patch 72 hour 12 mcg/hr apply 1 patch transdermally every 72 hours was prescribed on May 13, 2024, and was active as of May 23, 2024. Interview with Employee E2, the Director of Nursing on May 22, 2024, at 11:00 a.m. confirmed that the wrong dosage of Fentanyl had been ordered and applied to Resident R165. 28 Pa Code 211.2(a) Physician services 28 Pa Code 211.5(f)(g)(h) Clinical records 28 Pa Code 211.9(a)(1)(k) Pharmacy services 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing Services