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	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inglis House	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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471 Based on observations and staff interviews, it was determined that the facility failed to provide confidentiality of residents' personal health information during medication administration for one of two staff observed (Employee E6 and failed to ensure residents' privacy was maintained before entering rooms for two of 35 residents reviewed (Residents R9 and R62). Findings include: Observation of the first floor revealed on March 19, 2025, at 9:10 a.m. revealed that there was no nurse/staff at the medication cart. It was observed that there was numerous medication packet on top of the medication cart with resident's name, room number, name of medication and dosage of the medication printed on it. A medication administration observation was requested with Employee E6, Licensed Practical Nurse. Continued observation on March 19, 2025, at 9:20 a.m. revealed that Licensed Practical Nurse, Employee E6, was administering medication to the assigned residents. It was observed the medication packets were still on top of the medication cart with resident's name, room number, name of medication and dosage of the medication printed on it. Interview with Employee E6 on March 19, 2025, at 9:50 a.m. confirmed that she should not have left the medication packets with resident's personal information on the medication cart unattended open for everyone to see when leaving the medication cart. Review of clinical documentation revealed that resident R9 was admitted to the facility on [DATE]. Review of her most recent MDS (Minimum Data Set, a periodic assessment of resident care needs) assessment dated [DATE], revealed that she was assessed to have a BIMS (Brief Interview for Mental status, a tool used to assess a resident's cognitive status) score of 14 out of a possible 15, which indicated that the resident was cognitively intact. During a closed-door interview with Resident R9 in her room on March 17, 2025, at 11:43 a.m., a nurse aide opened the door and entered the room without knocking or introducing themselves. The staff member looked around the room, saw the resident was with the surveyor and left immediately. They did not identify themselves before exiting the room again. At this time Resident R9 confirmed that when staff enter the room, they don't always knock. At 11:49 a.m., a second staff member also entered the room, observed the room and left quickly all without knocking or identifying themselves. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of clinical documentation revealed that Resident R62 was admitted to the facility on [DATE]. Review of the resident most recent MDS assessment dated [DATE], revealed that the resident was assessed to have a BIMS score of 14 out of a possible 15, which indicated that the resident was cognitively intact. During a closed-door interview with Resident R62 in his room on March 18, 2025, at 12:12 p.m., a nurse aide opened the door and entered the room without knocking or introducing themselves. They left quickly without identifying themselves. The resident confirmed that this was a regular occurrence, and that it happened on all shifts. During an interview with the Nursing Home Administrator, Employee E1, and the Director of Nursing, Employee E2, on March 20, 2025, at 2:15 p.m., it was confirmed that it is the expectation of the facility that all staff must first knock and identify themselves before entering a room. 28 Pa. Code 201.29(j) Resident rights 28 Pa. Code 211.5(b) Clinical Records.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44882 Based on observation, clinical record review, and interviews with residents and staff, it was determined that the facility did not ensure timely revision of the comprehensive care plan related to wounds for one of 35 records reviewed (Resident R93). Findings include: Review of clinical documentation revealed that Resident R93 was admitted to the facility on [DATE], and had diagnoses including, but not limited to, Multiple Sclerosis, Muscle Weakness, Pressure Ulcer of the Sacral Region, and Open Wound of Lower Back and Pelvis. Review of the resident's physician orders revealed an order, revised March 18, 2025, for Santyl (an ointment used to treat wounds) to right ischium (area including the lower back and pelvis), every day shift for pressure wound. Review of the resident's care plan revealed that care plans had been developed for impaired skin integrity, specifying only left lower arm abrasion and scattered bruises and bruising of the left forearm and not the resident's current pressure wound to the right ischum. Observation of Resident R93 on March 18, 2025, at 12:36 p.m., revealed that there was an area of the resident's left forearm with what appeared to be slight bruising, but no abrasion. The resident confirmed that the abrasion had healed up a while ago. In an interview on March 20, 2025 at 11:30 a.m., the Director of Nursing, Employee E2, confirmed that the resident's pressure wound had not been added to the care plan as it should have been, and also that the resident's abrasion had resolved, and so should no longer have been included in the care plan. 28 Pa. Code 211.10 (d) Resident care policies 28 Pa. Code 211.12 (d)(5) Nursing services

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 41471 Based on a review of clinical records and interviews with staff, it was determined that the facility failed to meet professional standards related to medication administration for one of five residents reviewed (Resident R167). Findings include: According to the Pennsylvania Code Title 49, Professional and Vocational Standards Department of State, Chapter 21 State Board of Nursing, Chapter 21.145 Functions of the LPN (Licensed Practical Nurse) requires the following: (a) The LPN is prepared to function as a member of the health care team by exercising sound nursing judgement based on preparations, knowledge, skills, understandings, and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. (b) The LPN administers medication and carries out the therapeutic treatment ordered for the patient in accordance with the following: (d) The Board recognizes codes of behavior as developed by appropriate practical nursing associations as the criteria for assuring safe and effective practice. Review of physician order for Resident R167 dated, October 2, 2024, revealed a physician order Amlodipine Tablet (Medication that treats high blood pressure) 10 milligrams give 1 tablet by mouth daily in the morning; hold the medication for systolic blood pressure less than 110/70 or heart rate below 60. Observation on March 19, 2025, at 9:20 a.m. revealed that Licensed Practical Nurse, Employee E6, was administering medication to Resident R167. It was observed that the nurse checked the blood pressure and heart rate. The nurse administered the Amlodipine, after the administration surveyor asked nurse for the vital signs. The nurse stated blood pressure of 108/63 and pulse 71. Review of Medication Administration Record (MAR) for Resident R167 for the month of March 2025 revealed that on March 19, 2025, the systolic blood pressure was documented as 108 and diastolic pressure was 63. Further review of the MAR revealed that the nurse administered the medication. Interview with Employee E6, Licensed Practical Nurse, on March 19, 2025, at 9:20 a.m. stated that she should have held the medication for low blood pressure 28 Pa. Code:201.18(a)(b)(1)(3) Management. 28 Pa. Code:211.12(d)(1)(5) Nursing services.

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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	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** 46106 Based on a review of facility policy, clinical records, staff training records, information submitted by the facility, and staff and resident interviews, it was determined the facility failed to ensure the resident environment remained free of accident hazards resulting in actual harm to Resident R127 who sustained a second degree burn on the left knee when an employee's personal hot beverage spilled on the resident for one of 35 residents reviewed (Resident R127). This deficiency is cited as past non-compliance. Findings include: Review of facility policy Hours of Work revised October 24, 2020, revealed employees are not permitted to leave the facility's campus during break periods. Breaks must be taken in the cafeteria; employees lounge, or in similarly designated non-work areas. No food or beverage is permitted in direct service delivery work areas. Review of Resident R127's clinical record revealed the resident was admitted to the facility on [DATE], with a diagnosis of Quadriplegia (paralysis of all four limbs). Review of Resident R127's quarterly Minimum Data Set assessment (MDS- periodic assessment of resident's care needs) completed January 27, 2025, revealed the resident had a BIMS (Brief Interview of Mental Status) score of 13, which indicates the resident did not have cognitive impairment. The resident was assessed with upper and lower extremity impairments. Review of facility investigation initiated February 23, 2025, revealed Resident R127 was calling the aide while she was walking past the resident's room, to the staff lounge with her personal hot tea in her hand. Resident R127 was sitting in the wheelchair with the overbed table in front of the resident. The resident asked nurse aide, Employee E5 to empty the urinal that was place on the overbed table. Nurse aide, Employee E5 placed her personal hot tea cup with the lid on top on the resident's overbed table, then took took the resident's urinal to the bathroom located inside the room. She emptied the urinal in the toilet. When she opened the bathroom door, the door accidentally hit the overbed table, which knocked the tea cup over, and onto Resident R127's left knee and floor. The nurse aide Employee E5 called the charge nurse immediately. Review of Resident R127's nursing note dated February 23, 2025 revealed the resident sustained a burn to the left knee due to a tea cup on the table was accidentally knocked over and spilled on (his/her) left knee. On assessment left knee noted red and warm to touch, three peeling areas were noted. Resident complained of little pain upon touch. Ice applied to the area. All staff were educated on not to bring any hot beverages or personal items into resident's room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of statement by nursing aide, Employee E5 dated February 23, 2025, revealed I was on way down to the breakroom around 9:30 am with my own personal cup in my hand. On my way down [Resident R127] was calling my name. I stopped in to help him/her. (He/she) wanted me to do a couple things for (him/her). Employee E5 stated that she went to empty the resident's urinal, I put my cup on (his/her) table and opened the bathroom door and the door hit (his/her) table, then the cup fell on (his/her) leg and the floor. I called the supervisor. Employee E5 stated that at the time Resident R127 had long pants. When the nurse came into the room the resident's pants were wet. After the resident was assessment resident was changed to shorts. Review of statement by charge nurse, Employee E6 dated February 23, 2025, revealed charge nurse was called to resident room by care nurse. Upon entering room, care nurse stated that her cup with tea had accidentally been knocked over and spilled onto [Resident R127] left foot. Vital signs obtain Nurse Supervisor and charge nurse in to assess. Review of statement by Resident R127 completed by Director of Nursing, Employee E2, dated February 24, 2025, revealed, Resident R27 was alert and orientated x3 (oriented to person, place and time). Resident stated that yesterday February 23, 2025, the resident was sitting up in the wheelchair and bedside table in front of the resident. Resident R127 heard the aide passing by the room. Resident R127 called her to come in. This nurse aide, Employee E5, had her tea cup, when the resident asked her to empty the urinal, she placed her tea on the table. The table moved and accidentally spilled the tea on the resident's left knee. (Resident) stated it was accident. (Resident) wants to maintain the same nurse aide, Employee E5 for his/her care. Interview with Resident R127 on March 18, 2025, at 10:03 am, revealed and confirmed, on February 23, 2025, the aide helped with few tasks and placed her hot drink on the overbed table and it accidentally spilled on his/her knee and the floor. Resident R127 stated, as of right now everything is healed and did not hurt. Interview with the Nursing aide, Employee E5 on March 18, 2025, at 10:09 a.m. revealed, she was on her way down to the breakroom with her own personal hot tea on her hand. On her way down Resident R127 was calling her name. She stopped in to help the resident. The resident wanted her to do a couple things for (him/her). She went to empty the resident's urinal, I put my cup on [resident] overbed table and opened the bathroom door and the door hit (his/her) table, and the cup accidentally fell on (his/her) leg and the floor. I called the supervisor. Review of physician orders dated February 23, 2025 revealed an order was obtained for Triple Antibiotic External Ointment, with instructions to apply to left knee topically two times a day for peeling skin secondary to burn for 10 days, cleansed left knee with normal saline solution prior to administration. Review of physician documentation dated February 26, 2025, revealed, the resident skin was assessed with a second degree burn with partial thickness of the left knee. The wound team was scheduled for February 27, 2025. Review skin/wound documentation date on March 14, 2025, confirmed that Resident R127 was followed by the wound team and confirmed Wound 2 partial thickness radiation dermatitis/burn to left knee, status resolved. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	This deficiency was identified as actual harm past non-compliance for failure to ensure that Resident R127's environment remain safe which resulted in actual harm to Resident R127 when a staff's personal hot beverage spilled on the resident's left knee causing a second degree burn. On March 20, 2205, the Nursing Home Administrator presented documentation, indicating, the facility initiated a plan of correction on February 23, 2205, related to ensuring no personal drinks were brought into a resident's area. Review of facility Action plan/Follow up documentation revealed the following information. 1. The resident was immediately changed to shorts, and comforted by the DON and nursing lead, he remained on nursing report for close monitoring. Wound treatment initiated by the wound care nurse, on February 23, 2025, for triple antibiotic external ointment applied twice daily. Consult was for wound consultants on February 27, 2025, primary care physician saw him on February 25, 2025. 2. Visual audit of each floor was conducted to see if drinks were noted out of place. 3. Staff will be educated on the importance of not having drinks in resident areas. Employee received a counseling from the DON on February 23. 2025. The mother and resident R127 understood it was an accident and wanted to keep the staff member assigned to the resident. 4. Audits will be conducted weekly x 4 monthly x 2. The facility alleges compliance with their plan of correction as of March 17, 2025. Facility education record and competency record verified for completion. Staff were interviewed to verify education of facility policy on hot beverages or personal items. Random resident records reviewed to verify compliance with the facility policy on hot beverages and personal items. This deficiency was cited as past non-compliance. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47973 Based on review of clinical records, facility policy, observations, and staff interviews, it was determined that the facility failed to provide appropriate tracheostomy care for one of two residents reviewed receiving respiratory services. (Resident R43) Findings include: Review of facility policy titled, Tracheostomy- Care of dated March 3, 2028, revealed that consistent and proper care will be applied to prevent obstruction, growth of bacteria, respiratory complications, or skin breakdown. A review of Resident R43's clinical records revealed that the resident was admitted on [DATE], with diagnoses including, encounter for attention to tracheostomy. Further review of Resident R43's clinical records revealed a physician order dated, May 25, 2023, which indicated cuffed trach every shift, clean around tracheostomy and evaluate and document skin condition. Further review revealed an order dated May 25, 2025, for Trach:Blvona #6- Cuffless, indicating the tracheostomy tube size. Observations conducted on March 19, 2025, at 2:23 p.m. revealed Resident R43 had a tracheostomy tube size 6.0mm. Observations of the spare tracheostomy tube at bedside revealed a spare tube size 7.0mm. Further observations failed to reveal a date on the tracheostomy collar. The collar contained stains and appeared soiled. Interview with the Respiratory Therapist, Employee E21, conducted on March 19, 2025, at 2:25 p.m. confirmed that above mentioned finding. Further interview confirmed that the spare tracheostomy tube size is incorrect, and must be 6.0mm, per physician orders. Follow-up interview with the facility Director of Nursing Conducted on March 20, 2025, at 2:02 p.m. confirmed that the spare tracheostomy tube should be per physician order. 28 Pa. Code 211.12(d)(5) 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. 41471 Based on review of clinical records, staff and resident interviews, it was determined that the facility failed to provide culturally competent, trauma 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 four of four residents sampled for post-traumatic stress disorder(PTSD) care. (Resident R158, R113, R102, and R130). Findings include: A review of the clinical record revealed that Resident R158 was admitted to the facility, with diagnoses to include traumatic spinal cord dysfunction, depression (a common mental health condition characterized by persistent feelings of sadness, loss of interest, and low energy levels that can significantly impact daily life and post-traumatic stress disorder (PTSD)(a mental health condition that develops after experiencing or witnessing a traumatic event, such as a natural disaster, war, violent crime, or personal loss) A quarterly Minimum Data Set assessment (MDS- a federally mandated standardized assessment process conducted at specific intervals to plan resident care) for Resident R158 dated February 14, 2025, Section I, Active Diagnoses, Psychiatric/Mood Disorder, question I6100, indicated the resident has post-traumatic stress disorder (PTSD). Resident R158's current care plan, review completed on March 1, 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. A review of Resident R113's clinical record revealed that Resident R113 was admitted to the facility with diagnoses including anxiety disorder, depression, bipolar disorder, and PTSD. Resident R113's current care plan, date-initiated March 7, 2024, 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 past experiences and possible triggers that may cause traumatization. A review of Resident R102's clinical record revealed that Resident R102 was admitted to the facility with diagnoses including anxiety disorder, and PTSD. Resident R102's current care plan, date-initiated March 5, 2024, 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 past experiences and possible triggers that may cause traumatization. A review of Resident R130's clinical record revealed that Resident R130 was admitted to the facility with diagnoses including anxiety disorder, major depression disorder, bipolar disorder, and PTSD. Resident R130's current care plan, date-initiated November 16, 2024, 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 past experiences and possible triggers that may cause traumatization. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Social Service Director, Employee E12, on March 20, 2025, at 12:40 p.m. confirmed that Resident R158, R113, R102, and R130's care plan 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. Employee E12 stated it was not facility practice to ask the resident or family for PTSD or triggers and identify it on the care plan. 28 Pa. Code 211.12(c)(d)(3)(5) Nursing services

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 41471 Based on a review of facility documentation and interviews with staff, it was determined that the facility failed to complete performance reviews for five of five nurse aides' personnel files reviewed related to performance reviews as required (Employees E13, E14, E15, E16 and E17). Findings include: On March 19, 2025, annual performance reviews for Employees E13, E14, E15, E16 and E17 were requested from the Nursing Home Administrator and Director of Nursing. Facility did not provide annual performance reviews for Employees E13, E14, E15, E16 and E17 Interview on March 20, 2025, 1:16 p.m. the Nursing Home Administrator revealed that the facility had not completed any performance reviews for any staff for the current year or the past year, including Employees E13, E14, E15, E16 and E17. 28 Pa. Code 201.19(2) Personnel policies and procedures

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 44882 Based on review of facility records and interviews with staff, it was determined that the facility did not ensure that the record for reconciliation of controlled drugs was complete related to missing signatures on the Narcotic Count Sheet for one of five medication carts reviewed (3 North cart A). Findings include: Interview with licensed nurse, employee E7, on March 19, 2025, at 12:30 p.m. revealed that at each change of shift, the oncoming and outgoing nurses must verify that the recorded number of narcotics for each resident is consistent with the actual supply available, and it is the expectation that both nurses must sign the Narcotic Count Sheet after the reconciliation has been performed and verified. Review of the narcotic reconciliation documentation for the medication cart on the 3 North unit revealed that between the dates of March 12, 2025, and March 18, 2025, seven of 44 required nurse signatures were absent. Employee E7 confirmed that the signatures were absent. 28 Pa Code 211.9(a)(1) Pharmacy services 28 Pa Code 211.12(d)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44882 Based on observation, clinical record review and interviews with staff, it was determined that the facility failed to ensure that medications were stored and labeled properly related to labeling of open liquid medications, disposition of medication for discharge residents, and securing the cart lock when the nurse was not in sight for three of five medication carts reviewed (1 North cart A, 1 South cart B, and 3 North cart A). Findings include: Observation of first floor north cart one on March 19, 2024, at 9:30 a.m. with Employee E6, Licensed Practical Nurse, revealed that there was Insulin Degludec pen (treats diabetes by increasing your body's insulin levels to decrease your blood sugar. This medication is an injection) with no open date or expiration date. There was polyvinyl alcohol eye drop, and [NAME] tears eye drops both opened with no open date or expiration date/date to discard. Interview with Licesed staff, Employee E6, at the time of the observation confirmed that insulin pen should be discarded after 28 days of opening and eye drops should have an open date. Observation of first floor south cart two on March 19, 2024, at 9:54 a.m. with Employee E18, Licensed Nurse, revealed that there was a Humalog pen which had a date of December 19, 2024, and two Lantus insulin bottle with no open date or expiration date/date to discard. Interview with Licensed nurse, Employee E18, at the time of the observation confirmed that insulin should be discarded after 28 days of opening and it should be dated when opened. On March 19, 2025, at 12:16 p.m., the surveyor approached medication cart 3 North A to find it unlocked with the nurse not in sight. When Licensed nurse, employee E8, returned to the cart she confirmed that she had stepped into a patient room for just a second out of view of the cart, leaving it unlocked. Review of the 3 North A cart in the presence of Employee E8, revealed the following: Sucralfate Suspension 1 GM/10ML and Valproate Sodium Oral Solution 250 MG/5ML for resident R139 were open in the cart with no open date. GlycoLax Powder (Polyethylene Glycol 3350) for Resident R94 was open in the cart with no open date. Amantadine HCl Oral Solution 50 MG/5ML and Potassium Chloride Solution 40 MEQ/15ML for Resident R96 were open in the cart with no open date. GuaiFENesin Liquid 100 MG/5ML for resident R279 was open in the cart with no open date. Review of the resident's clinical record revealed that this medication had been discontinued in January of 2025. (continued on next page)

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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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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employee E8 confirmed these findings at the time of the observation. Interview with the Director of Nursing, employee E2, on March 19, 2025, at 1:45 p.m. revealed that it is the expectation of the facility that all multi-use medications be labeled clearly with the date on which they were opened. She also confirmed that nurses are to lock their carts securely any time it will be out of view. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(1)(2)(5) Nursing services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47973 Based on observations and interviews with staff, it was determined that the facility did not ensure that food was stored, prepared, distributed and served in accordance with professional standards for food service safety. Findings include: Review of facility policy titled, Solarium Dishwasher Usage, Revised March 19, 2025, revealed that, Chemical solutions shall be maintained at the correct concentration and Results of concentration checks shall be recorded. Further review revealed that for high temperature dishwashes, the was temperature should be 150-165 degrees Fahrenheit and The final rinse temperature shall be 180 F. Corrective actions shall be taken for final temperatures below the required final rinse temperatures. Review of facility policy titled, Food Preparation in Kitchen, dated March 12, 2018, revealed that all food products that are taken out of the original container or opened for food prep must be covered, labeled & dated. Initial tour of the Foodservice Department conducted on March 17, 2025, with the Foodservice Director (FSD), Employee E4, revealed the following food items in the walk-in refrigerator were opened, undated, and unlabeled: two cheddar cheese packages, mozzarella cheese package, one parmesan cheese container, and blue cheese package. Further observations in the refrigerator revealed three opened plastic containers of diced pears dated March 14, 2025; container of coleslaw dated March 9, 2025, and a potato salad dated March 9, 2025. Continued observations revealed four racks of marinated jerk chicken in the meat box, uncovered and exposed; and approximately 10 pounds of marinated chicken drumsticks and thighs were undated and unlabeled. The FSD confirmed the above-mentioned findings during the kitchen tour. Observations during a follow-up tour of the kitchen, on the third-floor nursing unit, revealed that the dish machine model required chemical sanitation with a minimum recommended level of 50-100ppm (parts per million) available chlorine. Review of facility documentation and interview with the Food Service Director (FSD), Employee E4 conducted on March 19, 2025, at 12:00 p.m. revealed that the facility utilized a High Temperature Machine on the first and second floor nursing units. Further interview and observations revealed that the second-floor nursing unit utilized a low temperature dish machine and required concentration checks. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Food Service Supervisor, Employee E3, conducted on March 19, 2025, at 12:00 p.m. revealed that she was utilizing the dish machine and confirmed that the dish machine on the unit is a low temperature machine. Further interview confirmed that the low temperature dish machine must be tested prior to use to ensure proper sanitizer concentration. Employee E3 proceeded to test the dish machine at the end of the cleaning cycle. Observations revealed that the test strip did not change color, indicating that the sanitizing solution was not present during cycle. Review of facility documentation failed to reveal documented evidence indicating that the temperature was tested before use to ensure proper sanitation levels. Follow-up interview with the FSD, Employee E4; Food Service Supervisor, employee E3; and facility administrator conducted at 12:15 p.m. confirmed the above-mentioned findings and that the dish machine was not tested prior to use after both meals (breakfast and lunch). Further interview confirmed that the dishware could not be properly sanitized. The facility failed to maintain the dish machine in proper working order. 28 Pa. Code 201.14(a) Responsibility of licensee

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 47973 Based on observations and an interview with staff, it was determined that the facility failed to properly dispose of facility garbage. Findings include: Initial tour of the Foodservice Department garbage area conducted on March 17, 2025, with the Foodservice Director (FSD), Employee E4, revealed the following: Observations of the trash area revealed debris and dirty plastics (gloves, cups, utensils) observed scattered on the ground around the dumpster. Further observations revealed severe urine like odor; opened gray trash bin filled with waste; and five large and opened cardboard boxes. Interview with Food Service, Employee E4 along duration of the tour confirmed observations of the dumpster area. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 207.2(a) Administrator's responsibility

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 41471 Based on review of facility protocol, observations, and staff interviews, it was determined that the facility failed to implement proper use of personal protective equipment (PPE) for resident's on enhanced barrier precautions during wound care and medication administration as ordered by the physician for four of 35 resident reviewed. (Resident R18, R78, R93, R112) Findings Include: Review of an undated facility policy Enhanced Barrier Precaution Review of physician orders for Resident R18 dated February 25, 2025, revealed that the resident was ordered for enhanced barrier precaution ESBL (Extended-Spectrum Beta-Lactamase, an enzyme produced by some bacteria that makes them resistant to certain antibiotics, including penicillin and cephalosporins) in the urine. Observation of the Resident R18's wound care on March 19. 2025, at 11:30 a.m. revealed that there was a sign placed outside the resident room to alert the staff and visitors of resident's enhanced barrier precaution status. The sign indicated to use gown, gloves for wound care along with other resident care activities with a potential for exposure. Continued observation revealed that Employee E11, Licensed Nurse and Employee E18, Licensed Nurse were providing wound care to Resident R18 to his left buttocks area. It was observed that both employees did not wear a gown for the wound care. During an interview Employee E11 stated she did not think that the wound care required enhanced barrier precaution. Review of current physician orders for Resident R78 active on March 19, 2025, revealed that the resident was ordered for enhanced barrier precaution. During a medication administration observation for Resident R78 with Employee E6, Licensed Nurse, it was observed that Employee E6 did not wear a gown during the administration of facial cream to the resident. Employee took the medication in her hand and applied to resident's face and neck. On March 19, 2025 at 9:04 a.m., prior to observation of wound care for Resident R93, a sign was noted on the resident's door indicating that she was on Enhanced Barrier Precautions. The sign stated that gown and gloves were to be use when performing high contact tasks, including wound care. When Certified Nurse Practitioner, Employee E9, and Licensed Nurses, Employees E10 and E11, performed wound care at this time, they did not wear the required gowns. On March 19, 2025 at 11:44 a.m., prior to observation of wound care for Resident R112, a sign was noted on the resident's door indicating that she was on Enhanced Barrier Precautions. The sign stated that gown and gloves were to be use when performing high contact tasks, including wound care. When Certified Nurse Practitioner, Employee E9, and Licensed Nurses, Employees E10 and E11, performed wound care at this time, they did not wear the required gowns. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services