STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395135	A. Building B. Wing	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pennypack Nursing and Rehabilitation Center	8015 Lawndale Avenue Philadelphia, PA 19111

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47975 Based on review of facility policy, review of clinical records, interviews with staff and residents, it was determined that the facility failed to implement the facility abuse policy for one of four residents reviewed . (Resident R1) Findings Include: Review of facility policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating last revised September 2022 states, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Further review of the facility policy revealed, 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator of the individual making the allegation immediately reports his or her suspicion to the following persons and agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman c. The resident's representative d. Adult protective services (where state law provides jurisdiction in long-term care); e. Law enforcement officials. f. The resident's attending physician; and g. The facility medical director 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. Within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R1's clinical record revealed that the resident was admitted to the facility December 6, 2018. Review of Resident R1's quarterly MDS (Minimum Data Set) from February 19, 2024 revealed that the resident had a BIMS (Brief Interview for Mental Status) score of 15, showing intact cognitive response. Review of Resident R1's medical diagnoses revealed diagnoses of Hereditary and Idiopathic Neuropathy, Anemia, Major Depressive Disorder, Post-Traumatic Stress Disorder, Insomnia, Abnormalities of Gait, Schizoaffective Disorder, and Anxiety Disorder. Review of nursing progress note from March 13, 2024 at 11:11 a.m. by license nurse, Employee E7 revealed Resident noted yelling out in the hallway. This nurse addressed the issue/concern with resident. Resident stated that she was sleeping in her bed when a CNA (nurse aide) pushed her wheelchair into her bed resulting in the wheelchair hitting her right knee. Resident is noted crying out in pain. Resident states abnormal amount of swelling but looks normal to this nurse. MD (physician) notified of incident and c/o (complaint) of pain to right knee. New order for x-ray to right knee. Review of nursing progress note from March 13, 2024 at 2:47 p.m. by license nurse, Employee E8 revealed, EMS (Emergency Medical Services) arrived on scene stated that they received call to take resident out. Call was not originated from facility. Resident states that she did not make call and was unaware of it's origins. Resident further states that she is not in destress and has no need of evaluation. Resident refused EMS and ER (emergency department). This nurse inquired if resident was sure that she did not want to be evaluated. Resident stated again for second time that she had no need and did not call nor did she want to go. On March 14, 2024 the Director of Nursing, Employee E2 came in to work and around 6:30 a.m. noticed a witness statement on her desk. The Director of Nursing Employee E2 then called the Nursing Home Administrator, Employee E1 and started an investigation. Interview held with Resident R1 on March 15, 2024 at 9:23 a.m. with Resident R1 revealed that on March 13, 2024 she was sleeping in bed and she heard nurse aide, Employee E6 wheel her roommate in and put her in to bed. The resident stated that she was laying in bed on her side with her leg propped up on her wheelchair and she was hit in the left knee with her wheelchair. Resident R1 then stated that nurse aide, Employee E6 stated she was going to punch me in the throat, gave me the finger, and then left the room. The resident stated she got up and started yelling and another nurse came to calm her down. She stated now that her leg is hurting but she in taking pain medication currently for liver pain. Interview and observation held with Resident R1 and Nursing Home Administrator Employee E1 on March 15, 2024 at 10:10 a.m. Resident R1 again stated that she made a mistake and her left knee was the one that was propped up on her wheelchair and hit. Resident R1 pulled up her left pant leg and that was noticeable yellow bruising on her left knee cap. Resident R1 pulled up her right pant leg and that was not bruising or swelling to the right knee cap. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview held with nurse aide Employee E6 on March 15, 2024 at 10:56 a.m. via phone. Nurse aide Employee E6 stated, I went into her room that morning and Resident R1's chair was in the walkway at the end of her bed. I went to nurse Employee E5 and asked her to communicate the issue. Licensed nurse, Employee E5 must have gone in and asked her to move the chair. A little while longer the chair was moved back and her foot was resting on it. I turned the chair to the left so I could get around. I turned the chair towards the door. Her foot was still resting in the chair a little so she could get past. Resident R1 then jumped up and started cursing at me. I said Resident R1, you have been asked if your butt is not in the chair you need to move it and it's in the way. Resident R1 was yelling and cursing at me and I said [Resident R1] the chair is the problem. She said go to hell and I said you go first. Further interview with nurse aide Employee E6 revealed, I was still on the same unit but was not allowed to go in Resident R1's room. Nurse aide Employee E6 stated that she has gone to Former Director of Nursing in regard to the issues she has been having with [Resident R1]. [Resident R1] has been known to have her wheelchair and walker in her room and she has been told not to. This situation between me and [Resident R1] has been escalating for weeks. I've had to tell [Resident R1] I am talking to your roommate mind your business. Interview held on March 15, 2024 at 11:11 a.m. with Licensed Nurse, Employee E9 in person who stated I was working a double on the other side (A side) when I heard commotion by the nurses station. Heard noises and the Police came inside and said someone called them. [Resident R1] refused to go. I overheard staff talking about a nurse aide hitting [Resident R1] with a wheelchair. I was working a double and Resident R1 was not my patient so I went back to continue giving out medications on my side. Interview held over the phone with licensed nurse Employee E7 at Interview held on March 15, 2024 at 12:08 p.m. Licensed Nurse, Employee E7 revealed, I was sitting at nursing station and I heard yelling. I jumped up and saw [Resident R1] yelling in the hall and rolling down the fall in her wheelchair. I said talk to me, [Resident R1] said she was sleeping and [nurse aide Employee E6] walked by and pushed her wheelchair into her bed and her knee got hit by the wheelchair. [Nurse aide Employee E4] told then told [nurse aide Employee E6] to write a witness statement. I wrote a nurses note, let the doctor know, and called in the order to do a x-ray. My shift was done at 11:00 a.m. because I left early that day. [Nurse aide' Employee E4] told [Nurse Aide' Employee E6] she could not go into that room the rest of the day. Interview held on March 15, 2024 at 12:20 p.m. nurse aide, Employee E4 in person and stated I was in the area of the nurses station sitting next to[licensed nurse Employee E7]. I heard a female voice from B-hall yelling and I said to [licensed nurse Employee E7] you need to get up and go investigate that. At that point she got up and went to investigate what was going on. At one point[licensed Nurse Employee E7] says the employee bumped the wheelchair on Resident R1's knee. I say to[licensed nurse Employee E7], you need to report this immediately. [Resident R1] was upset in the hallway, and I told her to go to the social worker and helped her down the hall to talk with the [social worker Employee E3]. I told [nurse aide Employee E6] not to go back in her room, because I make the assignments. I took the room for the rest of the shift and I worked until 11:00 p.m. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with license nurse, Employee E8 held on March 15. 2024 at 1:08 p.m. over the phone. Licensed nurse, Employee E8 stated, [Resident R1] never reported to him about abuse. I arrived at 2:45 p.m. shortly after coming in I received a phone call from a police officer who said he was calling to follow up and the call was then transferred to the[Social Worker Employee E3]. He stated he assumed abuse had been reported and the facility had called the police to report. Shortly after EMS showed up to take to take [Resident R1] to the hospital. EMS said they were there to take [Resident R1] to the hospital. I had thought the accusation of the abuse was reported to nurse was my impression. Then as time went on we thought her family member must have called. We asked her several times are you sure you don't want to get checked out, but she refused to go with EMS. I wrote a note that EMS showed up. I was working as the supervisor of the shift for the second shift, assigned to the desk. I did put in a note for an order for skin checks every shift. Interview held with the Nursing Home Administrator, Employee E1 and Director of Nursing, Employee E2 on March 15, 2024 at 2:01 p.m. and there were asked in the absence of the Nursing Home Administrator and Director of Nursing who oversaw the building to take action. The Nursing Home Administrator, Employee E1 and Director of Nursing, Employee E2 stated that the unit manager licensed nurse, Employee E7 would have been in charge. The Director of Nursing, Employee E2 stated that the only person notified of the incident the day that it occurred was social services. Interview held with Social Services, Director Employee E3 on March 18. 2024 at 9:35 a.m. revealed that on Wednesday [Resident R1] came into my office sobbing in the morning around 11:00 a.m. to11:30 a.m. She had said a nurse aid had rammed her wheelchair into the bed and it hurt her right knee. [Resident R1] was wearing pants and pulled up her pants to check both knees. The right knee was red swollen and appeared to have a [NAME]. The resident stated the aide said she would punch her in the throat and gave her the finger. [Nurse Aide Employee E4] came in and told [nurse aide Employee E]6 not to have contact with [Resident R1] for the rest of the day. I wrote up a grievance and she was in my office calming down for about twenty minutes total. Around 3:00 p.m. I took a phone call from the police, called to say he was calling regarding a reported assault-said to let [Resident R1] know a police report has been filed. Emergency Medical Services (EMS) came in around 3:00 p.m. and couldn't figure out who they were here to see. I leave around 3:00 p.m., and I was not sure if they were here for [Resident R1] or not. They could not figure out who it was they were here to see. The surveyor asked if the social worker reported the incident happening to any licensed nurse on shift? The social worker stated she assumed that since there were a bunch of people when the commotion was going in the hall, that I thought that the channel of communicating to everyone that needed to be done had already been completed. Interview with Nursing Home Administrator, Employee E1 on March 18, 2024 at 9:10 a.m. revealed an x-ray was completed for Resident R1 on March 17, 2024 of the left knee which showed contusions to the left knee. Interview held on March 18, 2024 at 11:55 a.m. with the Nursing Home Administrator and Director of Nursing Employee E2 confirmed that the employee identified was not immediately taken off of the shift. Nurse aid Employee E6 was still allowed to finish her shift and remained on the same unit at Resident R1. 28 Pa. Code: 201.18 (b)(1)(2) Management. 28 Pa. Code: 201.29(a)(c)(d) (j)(m) Resident rights.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47975 Based on observation, review of facility policy, review of facility documentation, review of clinical records, interviews with staff, and interviews with the resident it was determined the facility failed to conduct an investigation timely to rule out neglect and/or abuse for one of four sampled residents (Resident R1). Findings Include: Review of facility policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating last revised September 2022 states, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Further review of the facility policy revealed, 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator of the individual making the allegation immediately reports his or her suspicion to the following persons and agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman c. The resident's representative d. Adult protective services (where state law provides jurisdiction in long-term care); e. Law enforcement officials. f. The resident's attending physician; and g. The facility medical director 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. Within 24 hours of an allegation that does note involve abuse or result in serious bodily injury. Review of the clinical record indicated Resident R1 was admitted to the facility December 6, 2018. Review of Resident R1's quarterly MDS (Minimum Data Set) from February 19, 2024 showed a BIMS (Brief Interview for Mental Status) score of 15, showing intact cognitive response. Review of Resident R1's medical diagnoses revealed diagnoses of; Hereditary and Idiopathic Neuropathy, Anemia, Major Depressive Disorder, Post-Traumatic Stress Disorder, Insomnia, Abnormalities of Gait, Schizoaffective Disorder, and Anxiety Disorder. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of nursing progress note from March 13, 2024 at 11:11 a.m. by license nurse Employee E7 states, Resident noted yelling out in the hallway. This nurse addressed the issue/concern with resident. Resident stated that she was sleeping in her bed when a CNA pushed her wheelchair into her bed resulting in the wheelchair hitting her right knee. Resident is noted crying out in pain. Resident states abnormal amount of swelling but looks normal to this nurse. MD notified of incident and c/o (complaint) of pain to right knee. New order for x-ray to right knee. Review of nursing progress note from March 13, 2024 at 2:47 p.m. by license nurse Employee E8 revealed, EMS arrived on scene stated that they received call to take resident out. Call was not originated from facility. Resident states that she did not make call and was unaware of it's origins. Resident further states that she is not in destress and has no need of evaluation. Resident refused EMS and ER. This nurse inquired if resident was sure that she did not want to be evaluated. Resident stated again for second time that she had no need and did not call nor did she want to go. On March 14, 2024 the Director of Nursing, Employee E2 came in to work and around 6:30 a.m. noticed a witness statement on her desk. The Director of Nursing Employee E2 then called the Nursing Home Administrator Employee E1 and started an investigation. Interview held with Resident R1 on March 15, 2024 at 9:23 a.m. Resident stated that on March 13, 2024 she was sleeping in bed and she heard nurse aide Employee E6 wheel her roommate in and put her in to bed. The resident stated that she was laying in bed on her side with her leg propped up on her wheelchair and she was hit in the left knee with her wheelchair. Resident R1 then stated that nurse aide Employee E6 stated she was going to punch me in the throat, gave me the finger, and then left the room. The resident stated she got up and started yelling and another nurse came to calm her down. She stated now that her leg is hurting but she in taking pain medication currently for liver pain. Interview and observation held with Resident R1 and Nursing Home Administrator Employee E1 on March 15, 2024 at 10:10 a.m. Resident R1 again stated that she made a mistake and her left knee was the one that was propped up on her wheelchair and hit. Resident R1 pulled up her left pant leg and that was noticeable yellow bruising on her left knee cap. Resident R1 pulled up her right pant leg and that was not bruising or swelling to the right knee cap. Interview held with nurse aide Employee E6 on March 15, 2024 at 10:56 a.m. via phone. Nurse aide Employee E6 stated, I went into her room that morning and [Resident R1's] chair was in the walkway at the end of her bed. I went to nurse [Employee E5] and asked her to communicate the issue. [Licensed nurse, Employee E5] must have gone in and asked her to move the chair. A little while longer the chair was moved back and her foot was resting on it. I turned the chair to the left so I could get around. I turned the chair towards the door. Her foot was still resting in the chair a little so she could get past. [Resident R1] then jumped up and started cursing at me. I said [Resident R1], you have been asked if your butt is not in the chair you need to move it and it's in the way. [Resident R1] was yelling and cursing at me and I said [Resident R]1 the chair is the problem. She said go to hell and I said you go first. Further interview with nurse aide Employee E6 revealed, I was still on the same unit but was not allowed to go in Resident R1's room. Nurse aide Employee E6 stated that she has gone to Former Director of Nursing in regard to the issues she has been having with Resident R1. '[Resident R1] has been known to have her wheelchair and walker in her room and she has been told not to. This situation between me and [Resident R1] has been escalating for weeks. I've had to tell Resident R1 I am talking to your roommate mind your business. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview held on March 15, 2024 at 11:11 a.m. with Licensed Nurse, Employee E9 in person who stated I was working a double on the other side (A side) when I heard commotion by the nurses station. Heard noises and the Police came inside and said someone called them. [Resident R1] refused to go. I overheard staff talking about a nurse aide hitting [Resident R1] with a wheelchair. I was working a double and [Resident R1] was not my patient so I went back to continue giving out medications on my side. Interview held over the phone with licensed nurse Employee E7 at Interview held on March 15, 2024 at 12:08 p.m. Licensed Nurse Employee E7 revealed, I was sitting at nursing station and I heard yelling. I jumped up and saw [Resident R1] yelling in the hall and rolling down the fall in her wheelchair. I said talk to me, [Resident R1] said she was sleeping and [nurse aide Employee E6] walked by and pushed her wheelchair into her bed and her knee got hit by the wheelchair. [Nurse aide Employee E4] told then told [nurse aide Employee E6] to write a witness statement. I wrote a nurses note, let the doctor know, and called in the order to do a x-ray. My shift was done at 11:00 a.m. because I left early that day. [Nurse aide Employee E4] told [Nurse Aide Employee E6] she could not go into that room the rest of the day. Interview held on March 15, 2024 at 12:20 p.m. nurse aide, Employee E4 stated I was in the area of the nurses station sitting next to [licensed nurse Employee E7]. I heard a female voice from B-hall yelling and I said to[licensed nurse Employee E7] you need to get up and go investigate that. At that point she got up and went to investigate what was going on. At one point licensed [Nurse Employee E7] says the employee bumped the wheelchair on Resident R1's knee. I say to[licensed nurse Employee E7], you need to report this immediately. [Resident R1] was upset in the hallway, and I told her to go to the social worker and helped her down the hall to talk with the [social worker Employee E3]. I told [nurse aide Employee E6] not to go back in her room, because I make the assignments. I took the room for the rest of the shift and I worked until 11:00 p.m. Interview with license nurse, Employee E8 held on March 15. 2024 at 1:08 p.m. over the phone. Licensed nurse, Employee E8 stated, [Resident R1] never reported to him about abuse. I arrived at 2:45 p.m. shortly after coming in I received a phone call from a police officer who said he was calling to follow up and the call was then transferred to the [Social Worker Employee E3]. He stated he assumed abuse had been reported and the facility had called the police to report. Shortly after EMS showed up to take to take [Resident R1] to the hospital. EMS said they were there to take [Resident R]1 to the hospital. I had thought the accusation of the abuse was reported to nurse was my impression. Then as time went on we thought her family member must have called. We asked her several times are you sure you don't want to get checked out, but she refused to go with EMS. I wrote a note that EMS showed up. I was working as the supervisor of the shift for the second shift, assigned to the desk. I did put in a note for an order for skin checks every shift. Interview held with the Nursing Home Administrator Employee E1 and Director of Nursing Employee E2 on March 15, 2024 at 2:01 p.m. and there were asked in the absence of the Nursing Home Administrator and Director of Nursing who oversaw the building to take action. The Nursing Home Administrator Employee E1 and Director of Nursing Employee E2 stated that the unit manager licensed nurse Employee E7 would have been in charge. The Director of Nursing Employee E2 stated that the only person notified of the incident the day that it occurred was social services. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview held with Social Services Director Employee E3 on March 18. 2024 at 9:35 a.m. on Wednesday [Resident R1] came into my office sobbing in the morning around 11:00 a.m. to11:30 a.m. She had said a nurse aide had rammed her wheelchair into the bed and it hurt her right knee. [Resident R]1 was wearing pants and pulled up her pants to check both knees. The right knee was red swollen and appeared to have a [NAME]. The resident stated the aide said she would punch her in the throat and gave her the finger. [Nurse Aide Employee E4] came in and told [nurse aide Employee E6] not to have contact with [Resident R]1 for the rest of the day. I wrote up a grievance and she was in my office calming down for about twenty minutes total. Around 3:00 p.m. I took a phone call from the police, called to say he was calling regarding a reported assault-said to let [Resident R1] know a police report has been filed. Emergency Medical Services (EMS) came in around 3:00 p.m. and couldn't figure out who they were here to see. I leave around 3:00 p.m., and I was not sure if they were here for Resident R1 or not. They could not figure out who it was they were here to see.' The surveyor asked if the social worker reported the incident happening to any licensed nurse on shift? The social worker stated she assumed that since there were a bunch of people when the commotion was going in the hall, that I thought that the channel of communicating to everyone that needed to be done had already been completed. Interview with Nursing Home Administrator Employee E1 on March 18, 2024 at 9:10 a.m. confirmed that the licensed nurse Employee E7 and social worker Employee E3 failed to follow the abuse policy with reporting allegations of abuse of neglect immediately to the administrator. This failure resulted in a delay of investigation. 28 Pa. Code: 201.14 (a) Responsibility of licensee 28 Pa. Code: 201.14 (c) (e) Responsibility of licensee 28 Pa. Code 201.18 (e) (1) Management.