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	11/14/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on staff interviews, review of clinical records and review of facility documents, it was determined that the facility failed to ensure residents were assessed and monitored after fall incidents for one out of two residents reviewed (Resident R1).Findings include:Review of the facility policy, Assessing Falls and Their Causes, with a revision date of March 2018 indicated that the purpose of the policy is to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. The policy also stated that if a resident has a fall, or is found on a floor without a witness to the event, that staff is to be evaluated for possible injuries to the head, neck, spine and extremities; obtain and record vital signs as soon as it is safe to do so; notify the physician; provide appropriate first aide and/or obtain treatment immediately if there is evidence of injury; observe for delayed complications of a fall for approximately 48 hours.document any observed signs or symptom of pain, swelling, bruising, deformity, and any changes in level of responsiveness/consciousness and overall function. The policy also indicated that an incident report for the fall should be completed by the nursing supervisor on duty and the time, and submitted to the Director of Nursing. Continued review of the policy indicated that the resident's physician and family are to be notified in an appropriate time. Review of the November 2025 physician orders for Resident R1 included the diagnoses of dementia (progressive degenerative disease of the brain); anxiety; mild intellectual disabilities; lack of coordination; dysphagia (difficulty with swallowing). Review of the clinical record also indicated that the resident required the use of a wheelchair for mobility. Review of a nursing note dated November 1, 2025, at 7:23 p.m. stated that the resident was transferred to the emergency room due to swelling and bruising to the lower right extremity. Review of an incident report dated November 1, 2025, completed by the nursing supervisor (Employee E3) stated that the nursing supervisor was called to the resident's room and discovered scattered purpose bruising from the abdomen to the knee. The incident report indicated that the residents could not offer any information regarding the bruised areas.During an interview with the Director of Nursing (DON) on November 13, 2025 at 11:15 a.m. the DON reported that she was notified by the nursing supervisor (Employee E3) on November 1, 2025 of the bruised area on the resident and during the investigation of the bruise that was reported to her on November 1, 2025 by nursing supervisor (Employee E3). DON stated that she was notified that the resident had sustained a fall (s). Review of an interview dated November 3, 2025 that the Director of Nursing (DON) conducted with the nursing supervisor (Employee E3) for the 3:00 p.m. through the 11:00 p.m. nursing shift on October 29, 2025, Employee E3 revealed that during the 3:00 p.m. through the 11:00 p.m. nursing shift on October 29, 2025, at approximately 10:55 p.m. she heard a grunt and when she went to investigate, she saw the resident sitting on the floor in front of his wheelchair. The nursing supervisor reported in her statement that she did not complete a nursing assessment on the resident that she found on the floor because that fall occurred on 11:00 p.m. through the 7:00 a.m. nursing shift and the nurse for that shift needed to complete it. Review of interview dated November 5, 2025 conducted by the DON with Employee E5 (licensed nurse on the 10:45 p.m. through the 7:00 p.m. nursing shift) revealed that Employee E5 reported that he came in the building on October 29, 2025 and was in the process of putting his belongings away when he witnessed the resident sliding off the chair. Employee E5 reported that both he and a nurse aide picked the resident off the floor. Employee E5 also stated that the resident had a 2nd fall 20-25 minutes after the first fall. Continued interview revealed that when asked what he did after the falls, the licensed nurse reported that he did not do anything. Review of the resident's clinical record provided no evidence of a clinical note regarding any of the 2 reported falls, and no evidence that the resident was assessed by nursing staff (e.g. changes in resident's cognition; vital signs such as pulses, blood pressure and respiratory rate; assessing the resident's range of motion, skin integrity, pain, etc.) regarding any of the 2 reported falls.Review of the resident's clinical record did not show evidence that the physician was notified for any of the above referenced 2 falls that were reported by nursing staff to have occurred by licensed nursing staff. During an interview with the Director of Nursing on November 13, 2025, at 12:11 p.m. it was discussed and confirmed that nursing staff did not notify the physician of Resident R1 by facility staff after the 2 falls that nursing staff reported that he had.During an interview with the resident's attending physician on November 14, 2025, at 11:03 a.m. the physician confirmed that he was not notified by nursing staff that Resident R1 had a fall (s) on October 29, 2025 until November 1, 2025.28 Pa. Code 211.10(d) Resident care policies28 Pa. Code 211.12(d)(1)(5) Nursing services