

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395135	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2025
NAME OF PROVIDER OR SUPPLIER Pennypack Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on staff interviews and review of facility documentation, it was determined that the facility failed to conduct a complete and thorough investigation related to an allegation of potential abuse/neglect for 1 out of 13 residents reviewed (Resident R101)</p> <p>Findings include:</p> <p>Review of the June 2025 physician orders for Resident R101 included the following diagnosis: diabetes (a disease characterized by elevated levels of blood glucose); hypertension (high blood pressure); pressure ulcer of left hip (a bedsore that develops due to prolonged pressure on that particular area of the body), and heart failure (the heart is unable to pump enough blood to meet the body's needs).</p> <p>Review of information submitted from the facility and to the State Survey Agency on November 20, 2024 indicated that on November 20, 2024 Resident R101 reported that a nurse aide (Employee E8) shoved a bed pan under him which hit his pressure ulcer, causing him to have severe pain during the 3:00 p.m. -11:00 p.m. nursing shift. The resident also indicated that the nurse aide delayed providing him care by telling the resident that he/she would return to assist him after the resident told the nurse aide that he just had a bowel movement.</p> <p>Review of the undated witness statement submitted by nurse aide, Employee E8 indicated I care for the resident as I should of and never abused any resident. Continued review of the undated statement did not show evidence that the facility asked nurse aide, Employee E8 about the resident's allegations to ensure a complete and through investigation into the resident's allegations.</p> <p>Continued review of the investigation revealed two witness statements from 2 licensed nurses (Employee E9 and Employee E10) regarding the alleged incident.</p> <p>Review of the nursing schedule provided by the facility for the 3:00 p.m. through the 11:00 p.m. nursing shift on November 20, 2024 indicated that there were 4 additional nursing staff members who were working on the floor during that time who were not interviewed (licensed nurse Employee E11; nurse aide E12; nurse aide E13 and nurse aide E14).</p> <p>Continued review of the facility's investigation regarding the resident's allegations provided no evidence of documentation of any interviews with the above referenced staff on the 3:00 p.m. through the 11:00 p.m. shift regarding the resident's allegations against Employee E8.</p> <p>(continued on next page)</p>

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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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Director of Nursing (DON) on June 6, 2025 at 1:22 p.m. Employee E8's statement was reviewed with the DON and the above referenced concerns regarding the statement from the alleged perpetrator was discussed. It was also discussed during the interview with the DON that the facility did not have any statements from the 4 referenced nursing staff members who worked on the 3:00 p.m. through the 11:00 p.m. nursing shift on November 20, 2024.</p> <p>28 Pa. Code 201.14(a)(e) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1)(3)(e)(1) Management</p> <p>28 Pa. Code 201.29(c) Resident rights</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility policies and interviews with staff, it was determined that the facility failed to complete a discharge MDS assessment for one of 19 residents reviewed (Resident R9).</p> <p>Findings include:</p> <p>Review of facility policy, Resident Assessments dated March 2022, revealed, The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews.</p> <p>Clinical record review for Resident R9 revealed that the resident was admitted to the facility on [DATE], for short term rehabilitation. Review of progress notes revealed that the resident discharged home on February 3, 2025.</p> <p>Review of MDS (Minimum Data Set - a mandatory periodic resident assessment tool) assessments for Resident R9 revealed that a discharge MDS assessment had not been completed.</p> <p>Interview on June 5, 2025, at 9:03 a.m. the Director of Nursing confirmed that a discharge MDS had not been completed for Resident R9.</p> <p>28 Pa Code 201.14(a) Responsibility of licensee</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and review of clinical records, it was determined that the facility failed to develop and implement a baseline care plan for one of six new admissions reviewed (Resident R19).</p> <p>Findings Include:</p> <p>Review of facility policy on Care Plans-Baseline revealed that under section Policy Statement A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. Under section Policy Interpretation and Implementation #1. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: a. Initial goals based on admission orders and discussion with the resident/representative; b. Physician orders. c. Dietary orders. #2. The baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan (no later than 21 days after admission). The baseline care plan is updated as needed to meet the resident's needs until the comprehensive care plan is developed. #3.</p> <p>A comprehensive care plan may be used in place of the baseline care plan providing the comprehensive care plan is developed within 48 hours of the resident's admission and meets the requirements of a comprehensive assessment.</p> <p>Review of Resident R19's clinical record revealed that Resident R19 was admitted to the facility on [DATE], with diagnosis of Severe Protein Calorie Malnutrition.</p> <p>Further review of Resident R19's clinical record revealed that Resident R19 was transferred to a local hospital on December 20, 2025, was readmitted to the facility on [DATE], and was transferred back to a local hospital on December 31, 2024, and was readmitted back to the facility on January 5, 2025.</p> <p>Further review of Resident R19's clinical record revealed no documented evidence that a baseline care plan addressing Resident R19's severe protein calorie malnutrition and weight status was developed and implemented until January 8, 2025, when a comprehensive care plan was developed.</p> <p>Interview with facility dietician Employee E3 conducted on June 4, 2025, at 2:45 p.m. confirmed that there was no baseline care plan for nutrition.</p> <p>28 Pa Code 211.10(c) Resident care policies</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on observations, review of facility policies, clinical record reviews and interviews with staff, it was determined that the facility failed to follow physician orders during medication administration for one of five residents observed during medication administration (Resident R34).</p> <p>Findings include:</p> <p>Review of facility policy, Administering Medications dated April 2019, revealed, Medications are administered in accordance with prescriber orders.</p> <p>Observation on June 3, 2025, at 9:37 a.m. of morning medication pass revealed Employee E5, licensed nurse, prepare a lidocaine 4% patch (pain medication applied to the skin) and apply it to Resident R34's left shoulder.</p> <p>Review of physician's orders for Resident R34 revealed an order dated February 9, 2025, for lidocaine 5% patch, apply to left shoulder in the morning.</p> <p>Interview on June 3, 2025, at 2:10 p.m. Employee E5, licensed nurse, confirmed that Resident R34 was ordered a lidocaine 5% patch and that she administered a lidocaine 4% patch. Employee E5, licensed nurse, stated that there were only lidocaine 4% patches available in the medication cart and that she did not know where to get a lidocaine 5% patch.</p> <p>28 Pa Code 211.9(a)(1) Pharmacy services</p> <p>28 Pa Code 211.10(c) Resident care policies</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>Based on observations, review of facility policies, clinical record reviews and interviews with staff, it was determined that the facility failed to ensure appropriate enteral feeding practices related to labeling and implementing dietician recommendations for one of two residents reviewed related to enteral feeds (Resident R33).</p> <p>Findings include:</p> <p>Review of facility policy, Medical Nutrition Therapy: Assessment and Care undated, revealed, The Registered Dietician/Nutritionist (RDN) or other clinically qualified nutrition professional's recommendations for changes in the nutrition plan of care will be communicated to the licensed nursing team and Dining Services Director via the summary recommendations sheet. The RDN or other clinically qualified nutrition professional will be responsible for ensuring follow up and appropriate documentation of recommended changes in the plan of care.</p> <p>Observation on June 3, 2025, at 11:17 a.m. revealed Resident R33's enteral tube feeding (nutrition delivered directly into the gastrointestinal tract through a tube) of Glucerna 1.5 was infusing via a pump at 40 ml/hr (milliliters per hour) with water flushes of 74 ml every two hours. Continued observation revealed that there was no date on the bottle of when the Glucerna was opened and no name or date label on the bag for water flushes.</p> <p>Interview on June 3, 2025, at 11:19 a.m. Employee E5, licensed nurse, stated that Resident R33 receives continuous tube feedings, that the Glucerna was already infusing when she started her shift and that she did not know when the bottle was opened.</p> <p>Continued observation on June 4, 2025, at 9:34 a.m. revealed that Resident R33's tube feeding of Glucerna 1.5 was infusing via a pump at 40 ml/hr with water flushes of 74 ml every two hours.</p> <p>Review of physician order for Resident R33 revealed an order, dated May 7, 2025, for Glucerna 1.5 via continuous feed at 40ml/hr. Continued review revealed another order, date May 16, 2025, for water flushes of 75ml every two hours via auto flush (via feeding pump). Further review revealed an order, dated May 5, 2025, to delegate the task of writing dietary orders to a clinically qualified nutrition professional.</p> <p>Clinical record review for Resident R33 revealed a nutrition note, dated May 16, 2025, at 11:42 a.m. which indicated that the resident had weight loss and the registered dietician recommended to increase the tube feeding to Glucerna 1.5 at 50 ml/hr for 22 hours per day.</p> <p>Interview on June 4, 2025, at 2:31 p.m. the Director of Nursing stated that when the dietician makes recommendations, the dietician is expected to enter the order and then the nursing department verifies the order.</p> <p>(continued on next page)</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on June 4, 2025, at 2:45 p.m. Employee E3, dietician, stated that when she makes recommendations, she either verbally informs or emails the Director of Nursing, and that the Director of Nursing then reviews the recommendations and enters the order. Continued interview revealed that Employee E3, dietician, was unaware that her recommendations to increase Resident R33's tube feedings were not implemented and that the resident's water flushes were not set at the correct rate on the feeding pump.</p> <p>28 Pa Code 211.10(c) Resident care policies</p> <p>28 Pa Code 211.12(d)(3)(5) Nursing services</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and facility policies and procedures, observations, and interviews with staff, it was determined that the facility failed to provide respiratory care and supplemental oxygen according to physician's order for one of seventeen residents reviewed. (Resident R40).</p> <p>Findings include:</p> <p>Review of facility Policy on Oxygen Administration under section Purpose The purpose of this policy is to provide guidelines for safe oxygen administration. Under section Preparation #1. Verify that there is a physician's order for this procedure. Review the physician's orders for oxygen administration. Under section Steps in the Procedure #8. Turn on the Oxygen. Unless otherwise ordered, start the flow of the oxygen at the rate of 2 to 3 liters per minute.</p> <p>Review of Resident R40's clinical record revealed that Resident R40 was admitted to the facility on [DATE], with diagnoses of chronic obstructive pulmonary disease.</p> <p>Review of Resident R40's physician's orders revealed an order for; 02 (Oxygen) at 3 Liters via nasal cannula, every shift for SOB (shortness of breath)</p> <p>Observation conducted on Resident R40 during the tour of the facility conducted on June 3, 2025, at 12:24 p. m. revealed that Resident R40 was sitting up on her bed with nasal cannula connected to an oxygen concentrator. Observation of the oxygen concentrator revealed that the oxygen guage was set at 2 liters/minute.</p> <p>Interview with Resident R40 conducted at the time of the observation revealed that she did not know that her oxygen was at 2 liters and did not know who adjusted it.</p> <p>Interview with licensed nurse Employee E7 conducted on June 3, 2025, at 12:30 p.m. confirmed that the oxygen order for Resident R40 was oxygen at 3 Liters via nasal cannula, every shift for SOB (shortness of breath).</p> <p>Follow-up observation of Resident R40 conducted together with Employee E7 on June 3, 2025, at 12:38p.m. confirmed that Resident R40's oxygen was set at 2 liters/ minute. Employee E7 then proceeded to adjust Resident R40's oxygen concentrator to 3 liters/minute.</p> <p>28 Pa Code 211.12(d)(1) Nursing services</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>		

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<p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the resident and his/her doctor meet face-to-face at all required visits.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews and interviews with staff, it was determined that the facility failed to ensure physician visits were completed as required for one of 19 residents reviewed (Resident R4).</p> <p>Findings include:</p> <p>Review of Resident R4's Quarterly MDS (Minimum Data Set - a mandatory periodic resident assessment tool) dated May 2, 2025, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including cancer, heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), renal failure (a condition in which the kidneys lose the ability to remove waste and balance fluids) and dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities).</p> <p>Review of progress notes for Resident R4 revealed that there were no physician or practitioner notes from November 2024 through June 2025 available for review at the time of the survey. Continued review revealed that the last time the resident was seen by a physician was August 2, 2024.</p> <p>Interview on June 5, 2025, at 9:41 a.m. the Director of Nursing confirmed that there were no notes in Resident R4's clinical record from Resident R4's attending physician and that there were no notes from any physician or practitioner since August 2024 available for review at the time of the survey.</p> <p>28 Pa Code 201.14(a) Responsibility of licensee</p> <p>28 Pa code 211.2 (d)(3) Medical Director</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policy and staff interviews, it was determined that the facility failed to ensure that food was stored, prepared, distributed and served in accordance with professional standards for food service safety.</p> <p>Findings include:</p> <p>Review of the facility's undated Food Storage Policy, indicated that the Food Service Director and/or Cook(s) will ensure that all food items are stored properly, labeled and dated, and have 2 date system, which is the prepared date and use by date. Continued review of the policy also indicated that the Food Service Director and or cook(s) will ensure that all food items are stored properly by being in an air-tight container and labeled (if not in the original package) and dated with the receive date and then with opened and use by dates).</p> <p>During a tour of the dietary department on June 5, 2025 at 11:30 a.m. with the Food Service Director various food items were observed to have been opened, but not properly dated as follows:</p> <ul style="list-style-type: none"> -a bag of frozen cut green beans observed in the freezer were dated as being opened on June 5, 2025, but there was no use by date listed on the bag by the dietary staff. -a bag of frozen carrots observed in the freezer were dated as being opened on June 5, 2025, but there was no use by date listed on the bag by the dietary staff. -a pack of frozen hamburgers observed in the freezer were dated as being opened on May 5, 2025, but there was no used by date listed on the package by the dietary staff. -a gallon of milk observed in the refrigerator was dated as being opened on June 5, 2025, but there was no use by date listed on the container by the dietary staff. -a container of Italian dressing observed in the refrigerator had an open date of June 3, 2025, but there was no use by date listed on the container by the dietary staff. -a container of soy [NAME] sauce observed in the refrigerator that had been used by facility staff to prepare food was in observed in the refrigerator without an open date, and without a use by date. <p>During an interview with the Food Service Director on June 5, 2025 during the tour which started at 11:30 a. m. the food service director reported that the food items should display a date that the food item was opened by the food service staff and a and a use by date should also be displayed.</p> <p>28 PA Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(3) Management</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>Based on observations, review of facility policies and interviews with staff, it was determined that the facility failed to ensure that personal foods were stored and labeled in accordance with food safety standards for one of one medication rooms reviewed (A/B Wing medication room).</p> <p>Findings include:</p> <p>Review of facility policy, Medication Storage and Labeling dated 2001, revealed, Medications are stored separately from food and are labeled accordingly.</p> <p>Review of facility policy, Foods Brought by Family/Visitors dated March 2022, revealed, Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that it is clearly distinguishable from facility-prepared food.</p> <p>Observation of the A/B wing medication storage room on June 3, 2025, at 9:47 a.m. with Employee E5, licensed nurse, revealed a container of food, that was unlabeled and undated, stored in a refrigerator that contained vaccines.</p> <p>Interview, at the time of the observation, Employee E5, licensed nurse, confirmed the above finding and stated that she did not know who the food belonged to or when it was from.</p> <p>28 Pa Code 205.25(b) Kitchen</p>