STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395193	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosemont Center	35 Rosemont Avenue Rosemont, PA 19010

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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. 36609 Based on observation, clinical record review, and review of facility documentation and staff interview, it was determined that the facility failed to ensure that the resident's rights to privacy and confidentiality of his/her medical records was maintained for one of 24 residents observed (Resident R28). Findings include: Upon request of facility's HIPAA (Health Insurance Portability and Accountability Act) policies and procedures, the facility provided surveyors with the facility's HIPAA Training Program on confidentiality. Review of facility HIPAA Training Program on confidentiality revealed that policy statement. All facility personnel, including business associates, are required to attend our HIPAA Compliance training program. Under section Policy Interpretation and Implementation. Number one to ensure the confidentiality of our residents protected health information and facility information, HIPAA and Data Security training program will be provided for all employees and business associates who have access to protected health and facility information. The HIPAA training program includes, but is not limited to, an overview of the HIPAA guidelines and regulations relative to the protection of resident and facility information. A review of our facilities HIPAA policies and procedures. Review of the United Stated Department of Health and Human Services Health Insurance Portability and Accountability Act, https://www.hhs.gov/hipaa/for-professionals, revealed The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Secretary of the U.S. Department of Health and Human Services (HHS) to develop regulations protecting the privacy and security of certain health information. 1. To fulfill this requirement, HHS published what are commonly known as the HIPAA Privacy Rule and the HIPAA Security Rule. The Privacy Rule, or Standards for Privacy of Individually Identifiable Health Information, establishes national standards for the protection of certain health information. The Security Standards for the Protection of Electronic Protected Health Information (the Security Rule) establish a national set of security standards for protecting certain health information that is held or transferred in electronic form. The Security Rule operationalizes the protections contained in the Privacy Rule by addressing the technical and non-technical safeguards that organizations called covered entities must put in place to secure individuals' electronic protected health information (e-PHI). Within HHS, the Office for Civil Rights (OCR) has responsibility for enforcing the Privacy and Security Rules with voluntary compliance activities and civil money penalties. (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	For internal uses, a covered entity must develop and implement policies and procedures that restrict access and uses of protected health information based on the specific roles of the members of their workforce. These policies and procedures must identify the persons, or classes of persons, in the workforce who need access to protected health information to carry out their duties, the categories of protected health information to which access is needed, and any conditions under which they need the information to do their jobs. Observation of the second-floor unit conducted on October 8, 2024, from 7:23 a.m. to 10:45 a.m. revealed that a medication cart was parked in the hallway across from the nurse's station unattended. Further observation revealed that the laptop computer was open with resident information for Resident R28 was visible to passersby. On October 8, 2024 at 10:00 a.m. during observation of Registered Nurse, Employee E6's medication administration, the surveyor observed a computer mounted on the wall, open, revealing names of residents and clinical documentation without a staff member attending the commuter. Registered Nurse, Employee E6 explained the computers found mounted on the walls in residents' hallways are for the aides to document on their residents. 28 Pa. Code 211.29(j) Resident Rights

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609 Based on review of clinical record review, review of facility documentation and interview with staff, it was determined that the facility failed to ensure that resident/resident representative were notified of resident's discharge/transfer for three of three residents reviewed (Resident R11, R41, R42) Findings include: Request for the policy on Resident/Resident Representative and Ombudsman notification of resident's discharge/transfer revealed that the facility was not able to produce a policy. Review of Resident R11's clinical record revealed that Resident R11 was transferred to a local hospital on September 28, 2024, after a seizure episode which resulted in a fall. Further review of Resident R11's clinical record revealed no documented evidence that the facility notified the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. Review of Resident R41's clinical record revealed the resident was admitted to the facility diagnosed with epilepsy, depression, anxiety and past suicide attempts prior to admission. Review of Resident R41's progress notes revealed on January 22, 2024, noted the resident with suicidal ideations when the resident stated, She was going to put a plastic bag over her head. Nursing received further instructions to send the resident to the hospital for evaluation. On January 23, 2024, the resident returned to the facility. Review of Resident R42's clinical record revealed that Resident R42 was transferred to a local hospital on August 12, 2024, and was readmitted back to the facility on [DATE]. Further review of Resident R42's clinical record revealed no documented evidence that the facility notified the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. Interview with Director of Nursing (DON) Employee E2 conducted on October 10, 2024, at 1:19 pm revealed that they do not send discharge notification letter to the resident/family. Further interview with the DON confirmed that the facility did not send a written notification to Resident R11, Resident R41, Resident R42, and Resident R46 and to their representatives of their transfer to the hospital. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(2) Management

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508 Based on a review of clinical records, review of the Resident Assessment Instrument and staff interviews, it was determined that the facility failed to conduct a significant change Minimum Data Set Assessments (MDS - a federally mandated standardized assessment process conducted at specific intervals to plan resident care) for one of twenty-four residents reviewed who had a below the knee amputation (Resident R59). Findings include: Review of Resident R59's clinical record revealed that Resident R59 was initially admitted to the facility on [DATE], with a most recent readmission of September 15, 2024, from a local hospital status post (S/P or after) Right Below the Knee Amputation. Further review of Resident R59's clinical record revealed that Resident R59 had the following diagnoses Acute Osteomyelitis of the right ankle and foot dated July 20, 2024, Type two Diabetes Miletus dated July 20, 2024, and Acquired Absence of Right Leg Below the Knee dated September 16, 2024. Review of Resident R59's clinical record revealed a progress note dated September 15, 2024, indicating that Resident R59 arrived at facility from local hospital via stretcher accompanied by 2 transporters. readmitted with a diagnosis of RBKA (Right Below the Knee Amputation) related to osteomyelitis to right foot. Further review of Resident R59's physician orders revealed the following orders: Physician's order for NWB to RLE (No Weight wearing to right lower extremity-putting weight on the right foot is not allowed) dated September 15, 2024. Skilled PT (physical Therapy) services 3-5x/week for 30 days for therex, ther act, neuro [NAME], gait training, manual therapy dated September 17, 2024. Skilled OT services 3-5x/week for 30 days for therex, ther act, neuro [NAME], selfcare activities, manual therapy dated September 16, 2024 one time a day. Physician's order dated September 30, 2024, for: Wound Care: Right BKA (below knee amputation) Cleanser: wound cleanse secondary: kerlix, and secure wtih tape, ACE wrap. Frequency: 2x/week (and PRN- as needed) Monitor for signs and symptoms of infection every day shift every Mon, Thu. Further review of the Resident R59's clinical record revealed a quarterly MDS (minimum data set- a federally required resident assessment completed at a specific interval) with an ARD (Assessment Reference Date- the date the assessment period begins with specific look back date for different areas) of September 27, 2024. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Regional RNAC (Registered Nurse Assessment Coordinator), Employee E7 revealed that resident's S/P BKA should have triggered a significant change MDS assessment (A significant change in status assessment is required for a resident in a Medicare or Medicaid certified nursing home when a resident's health status experiences a major decline or improvement that meets the following criteria: a. The change is not expected to resolve on its own or with standard clinical interventions, b. The change affects more than one area of the resident's health, c. The change requires a revision or interdisciplinary review of the resident's care plan. The Significant Change MDS Assessement must be completed within 14 days of the determination that a significant change has occurred. The RN (Registered Nurse) Assessment Coordinator must sign the MDS as complete within this time frame. Further interview with, RNAC, Employee E7 revealed that she scheduled a significant change assessment for Resident R59's Status Post Below the Knee Amputation. 28 Pa. Code 211.12(c)(d)(3)(5) Nursing services

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609 Based on review of clinical records and interviews with staff, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 6 of 18 resident records reviewed (Residents R17, R41, R44, R48, R49, and R59). Findings include: Review of Resident R17's clinical record revealed the resident was initially admitted to the facility on [DATE], diagnosed with Acute and Chronic Respiratory Failure With Hypoxia (a condition that occurs when the body doesn't have enough oxygen in its tissues); and was ordered, dated August 6, 2024, with oxygen at 2L/Min, via nasal cannula continuously, every shift, related to acute and chronic respiratory failure with hypoxia (low lwvels of oxygen) On October 10, 2024, at 1:13 p.m., Resident R17 was observed that R17 receiving oxygen via nasal canula. which was confirmed with Licensed Nurse, Employee E5. Further review of Resident R17's clinical record revealed no evidence of a plan of care developed for Resident R17's oxygen administration. On October 10, 2024, at 1:15 p.m., interview with Licensed Nurse, Employee E5, confirmed that the facility failed to develop a care plan for Resident R17's oxygen administration in a timely manner. Review of Resident R41's clinical record revealed the resident was initially admitted to the facility on [DATE], diagnosed with epilepsy (a chronic brain disorder that causes seizures, which are episodes of involuntary brain activity that can affect the body) and given 500 mg of Keppra two times a day to prevent seizures. Nursing progress note, dated March 27, 2024, noted Resident R41 with seizure activity. The physician was notified and orders for blood work to verify the Keppra levels were at therapeutic levels. Further review of Resident R41's clinical record revealed no evidence a plan of care was developed for Resident R41's diagnosis of epilepsy. On October 11, 2024 at 10:00 a.m. interview with the Director of Nursing, Employee E2 confirmed the facility failed to develop a care plan for Resident R41's diagnosis of Epilepsy. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R44's clinical record revealed the resident was initially admitted to the facility on [DATE], diagnosed with Rhabdomyolysis (the breakdown of muscle tissue that leads to the release of muscle fiber contents into the blood. These substances are harmful to the kidney and often cause kidney damage); and was ordered on September 20, 2024, to change urinary indwelling foley catheter (16 F with 10ml balloon), (Foley catheter is a flexible tube that drains urine from the bladder into a collection bag), change as needed, based on clinical indications such as infection, obstruction, or when the closed system is compromised. On October 10, 2024, at 12:19 p.m. Resident R44 was observed with a urinary catheter in place. Further review of Resident R44's clinical record revealed no evidence of a plan of care was developed for Resident R44's indewelling urinary foley catheter administration, in a timely manner. On October 10, 2024, at 12:22 p.m., interview with Licensed staff, Employee E4, confirmed that the facility failed to develop a care plan for Resident R44's foley catheter. Review of Resident R48's clinical record revealed that Resident R48 was initially admitted to the facility on [DATE], with a most recent readmission of September 28, 2024. Further review of Resident R48's clinical record revealed that Resident R48 had the following diagnoses of Urinary Tract Infection, Hemiplegia/Hemiparesis, Benign Prostatic Hyperplasia with lower Urinary Tract Symptoms, Presence of Urogenital Implant, Retention of Urine. Review of Resident R48's clinical record revealed a physician's order dated September 28, 2024, to: Change Foley Catheter: Size: 16fr- change prn based on clinical indications such as infection, obstruction, or when the closed system is compromised as needed and every day shift starting on the 8th and ending on the 8th every month for catheter change. Further a physician's order dated September 28, 2024, was obtained for Foley Catheter Care every shift. Observation conducted during tour of the facility on October 8, 2024, from 7:23 a.m. to 10:45 a.m. revealed that Resident R48 had a urinary catheter in place connected to a urine bag. Further Review of Resident R48's clinical record revealed that there was comprehensive person-centered care plan for urinary catheter in place for Resident R48. Interview with DON (Director of Nursing) Employee E2 conducted on October 10, 2024, at 9:50 a.m. confirmed that there was no comprehensive patient-centered care plan for catheter use in place for Resident R48. Review of Resident R49's clinical record revealed that Resident R49 was admitted to the facility on [DATE], with diagnoses of Quadriplegia, S/P Fusion of the spine (Cervical Region), Renaud's Syndrome, Muscle Weakness. Review of Resident R49's Occupational Therapy (OT) discharge summary dated August 8, 2024, revealed a discharge recommendation for splint/brace and AROM (Active Range of Motion) and PROM (Passive Range of Motion) for transfers and grooming (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R49's physician's order revealed an order SPLINT: RUE (right upper extremity) resting hand splint, on after lunch meal daily and worn per tolerance; patient may remove independently, March 14, 2024 Further review of Resident R49's clinical record revealed that there was no person-centered comprehensive care plan related to splinting and for active range of motion. Interview with DON Employee E2 conducted on October 10, 2024, at 12:28 pm confirmed that there was no person-centered comprehensive care plan for splinting in place for Resident R49. Review of Resident R59's clinical record revealed that Resident R59 was initially admitted to the facility on [DATE], with a most recent readmission of September 15, 2024. Further review of Resident R59's clinical record revealed that Resident R59 had the following diagnoses Acute Osteomyelitis of the right ankle and foot dated July 20, 2024, Type two Diabetes Miletus dated July 20, 2024, and Acquired Absence of Right Leg Below the Knee dated September 16, 2024. Review of Resident R59's clinical record revealed a progress note dated September 15, 2024, indicating that Resident R59 arrived at facility from local hospital via stretcher accompanied by 2 transporters. readmitted with a diagnosis of RBKA (Right Below the Knee Amputation) related to Osteomyelitis to right foot. Further review of Resident R59's clinical record revealed that there was no person-centered comprehensive care plan related to Resident R59's below the knee amputation. Interview with DON Employee E2 conducted on October 10, 2024, at 12:28 pm confirmed that there was no person-centered comprehensive care plan for below the knee amputation for Resident R59. 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 46508 Based on observations, review of facility policy, review of clinical records, and staff and resident interviews, it was determined that the facility failed to ensure a resident with limited range of motion received treatment and services to maintain or improve range of motion/mobility for one of 24 residents reviewed for limited range of motion (Resident R49). Findings include: Review of Resident R49's OT (Occupational Therapy) discharge summary dated August 8, 2024, revealed a discharge recommendation for splint/brace and AROM (active range of motion) and PROM (passive range of motion), transfers and grooming. Review of Resident R49's physician's order dated March 14, 2024, revealed Splint: RUE (right upper extremity) resting hand splint, on after lunch meal daily and worn per tolerance; patient may remove independently. Review of Resident R49's March 2024- October 2024 Treatment Administration Record no documented evidence that donning and doffing of splint was performed. Further review of resident R49's clinical record revealed that there was no documented evidence that the donning and doffing of splints was performed. Interview with (DON) Director of Nursing Employee E2 conducted on October 10, 2024, at 11:51 am, confirmed that there was no documented evidence for the donning and doffing of splint according to rehab recommendations and according to physician orders. 28 Pa. Code 211.12 (d)(1)(3) 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** 39343 Based on observation, clinical record review, review of facility policy and staff interview, it was determined that the facility failed to provide appropriate respiratory care and services for two of 18 residents reviewed (Residents R17, R38). Findings include: Review of Resident R17's clinical record revealed the resident was initially admitted to the facility on [DATE], diagnosed with Acute and Chronic Respiratory Failure with Hypoxia (a condition that occurs when the body doesn't have enough oxygen in its tissues); and was ordered, dated August 6, 2024, with oxygen at 2 liters/min, via nasal cannula continuously, every shift, related to acute and chronic respiratory failure with hypoxia (low levels of oxygen). On October 10, 2024, at 1:13 p.m., observed that Resident R17 was administered oxygen at 3 liters/min via nasal canula. and not 2 liters/min, as ordered by the physician, and the same was confirmed with a Licensed Nurse, Employee E5, at the time of the finding. Review of Resident R38's clinical record revealed the resident was initially admitted to the facility on [DATE], diagnosed with Asthma (a chronic lung disease that causes inflammation in the airways, making it difficult to breathe); and was ordered, dated August 22, 2024, with oxygen at 2 Liters/Min, via nasal cannula, as needed, related to asthma (a condition in which the airways narrow and swell and may produce extra mucus). On October 8, 2024, at 8:53 a.m., observed that Resident R38 was administered with oxygen at 5 liters/min via nasal canula., and not 2 liters/min, as ordered by the physician, and the same was confirmed with a Licensed Nurse, E5, at the time of the finding. 28 Pa. Code 211.10 (c) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 39343 Based on observation, and interviews with staff, it was determined that the facility failed to maintain an effective infection control program related with wound treatment for one out of one resident observed and disinfecting of medical equipment (R44). Findings include: Review of physician order for Resident R44, dated September 27, 2024, indicated to administer wound care to right hip to right buttock, with cleanser: normal saline, Primary; Santyl, Calcium Alginate; Secondary: bordered gauze dressing, every shift and as needed; apply Santyl to the Slough and Eschar only, every shift to maintain Skin Integrity and every 8 hours, as needed to maintain skin integrity. On October 10, 2024, at 12:22 p.m., observed the wound treatment administered to Resident R44, by a Licensed Practical Nurse (LPN), Employee E4. It was observed that Employee E4, transported the whole treatment cart into R44's room, the room which was marked for Enhanced Barrier Precaution. Employee E4 was observed cleansed the wound of R44 without following the rule to cleanse from center to outer side of the wound. Further observation revealed that Employee E4 walked out of Resident R44's room with the contaminated Personal Protective Equipment (Gown). The above findings were confirmed at the time of the observation with Employee E4. 28 Pa. Code 211.10(d) Resident care policies 28 Pa Code 211.12 (d)(1)(5) Nursing services