

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395278	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/26/2024
NAME OF PROVIDER OR SUPPLIER  Saint Joseph Villa		STREET ADDRESS, CITY, STATE, ZIP CODE  110 West Wissahickon Ave Flourtown, PA 19031	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46106</p> <p>Based on review of facility documentation, review of clinical record, and staff interview, it was determined that the facility failed to maintain an environment free from hazards related to an unlocked bed wheel brake for one of 20 residents reviewed. (Resident R83)</p> <p>Findings include:</p> <p>A review of clinical record for Resident R83 revealed that the resident was admitted to the facility on [DATE], with diagnoses including anoxic brain damage, abnormal posture, and unspecified mental disorder due to known physiological condition.</p> <p>Review of Resident R83's quarterly Minimum Data Set (MDS- assessment of resident's care needs) date on April 9, 2024, revealed that the resident was assessed a requiring one-person physical assist for bed mobility.</p> <p>Review of Resident R83's care plan on May 5, 2023, revealed that Resident R83 was able to turn and reposition in bed with the assistance one person assist for bed mobility.</p> <p>Review of incident note dated on April 16, 2024, confirmed, and revealed that Resident R83 rolled off side of bed during care and hit head has a laceration to L (left)-forehead. Resident R83 has aphasia-unable to say what happened.</p> <p>Review of facility investigation dated, April 16, 2024, revealed that during incontinence care Resident 83 slid down between the bed and the wall to the floor while nurse aide, Employee E7 was turning resident to the right side to wash her back. Resident was transfer to the hospital.</p> <p>Review nurse aide, Employee E7, statement on April 16, 2024, stated that resident rolled out of bed due to bed moving as I was giving care. I immediately got the nurse and aide.</p> <p>Review of nursing documentation notes on April 16, 2024 3:26 p.m. revealed that Assessed forehead laceration, band-aid removed. 2.7cmx 2.5cm, 100% approximated with steri-strips, dried blood to medial aspect and upper right edge. No drainage, surrounding skin intact. Left open to air. Returned from ER at 12:15 p.m. assisted into bed. Forehead laceration with steri strips and band aid. Abrasion Left shoulder s/p fall. NO CT evidence for acute intracranial hemorrhage or mass effect</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on April 24, 2024, at 1:41 p.m. with the Director of Nursing, Employee E2, revealed Resident R83 slid down between the wall and bed after nursing assistant turning resident to the right side to wash her back. The reason why resident slid down was because the bed wheels brakes were unlocked.</p> <p>Interview on April 25, 2024, at 10:49 a.m. with nursing assistant, Employee E7, revealed that assumed top brakes were lock but they were unlock.</p> <p>28 Pa Code 211.10(c) Patient care policies</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>43923</p> <p>Based on observation, review of facility policy and staff interview, it was determined that the facility failed to maintain acceptable practices for the storage and service of food related to labeling and storage of foods in the main kitchen.</p> <p>Findings include:</p> <p>Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food).</p> <p>A review of a facility policies entitled Food and Supply Storage last reviewed by the facility on January, 2021, indicated that All food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. Under Procedures it further states, Cover, label and date unused portions and open packages. Complete all section on the . orange label or use the .Fresh date or other approved labeling system.</p> <p>Observations conducted during the initial tour of the kitchen with the facility's Dietary Manager, Employee E6 on April 23 , 2024, at 9:36 a.m., revealed the following:</p> <p>Walk in freezer had items such as frozen pies, chocolate cakes, chicken nuggets that were opened but not labeled.</p> <p>Walking in dairy refrigerator #1 had opened cheeses and slicing meats that were only dated with one date, and it was unclear if that was opened date or expiration date.</p> <p>Walk in refrigerator #2 had left over pasta that was not labeled.</p> <p>Dry Storage room had items such as dry peas, rice bags, spices whole poppy seeds, ground oregano, rosemary leaves, hollandaise mix, dry crispy onion, creamy rice and large containers of sugar, rice, flour, and thickener were all open and were not labeled with any dates.</p> <p>On April 26, 2024, at 9:41 a.m. more observations were made in the kitchen with Dining Manager, Employee E10 revealed refrigerator #2 had produce pasta left uncovered and unlabeled. Raw salmon packaged in the clear bag was stored on the middle shelf and there was veggie produce beneath. A cart full of ready to serve food which had a sheet of shrimp that was not covered or dated.</p> <p>Dry Storage room continued to have items peppermint pieces, pasta, sea food breadring mix, granola, chips, thickener, sugar, flour, rice in large bins that were not labeled with any dates.</p> <p>(continued on next page)</p>		

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