

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  03/03/2025
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38735</p> <p>Based on review of facility policy, review of clinical record, observations, and staff interviews, it was determined that the facility failed to develop and implement interventions per the comprehensive care plan for two of 21 residents reviewed (Resident R306 and R67).</p> <p>Findings Include:</p> <p>Review of facility policy Care Plans, Comprehensive Person-Centered revised March 2022 revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.</p> <p>Review of Resident R306's clinical record revealed the resident was admitted to the facility on [DATE], status post a mechanical fall at home on February 12, 2025, resulting in a left hip fracture and subsequent left hip surgery on February 14, 2025.</p> <p>Continued review of Resident R306's clinical record revealed an admission summary dated February 18, 2025, that revealed Resident R306 was weight bearing as tolerated (WBAT) with posterior hip precautions for six weeks.</p> <p>Review of Resident R306's comprehensive care plan dated February 18, 2025, revealed the resident had an activities of daily living self-care performance deficit related to deconditioning, limited mobility, limited range of motion, and status post left hip surgery. Intervention dated February 18, 2025, revealed Resident R306 should be transferred with assistance of two staff.</p> <p>Observations on February 25, 2025, at 1:27 p.m. revealed Resident R306 was assisted with one staff member, Nurse Aide Employee E8, from her recliner chair into a weighing chair scale in her room.</p> <p>Interview on February 25, 2025, at 1:30 p.m. with Nurse Aide, Employee E8, confirmed this employee transferred Resident R306 from the recliner into the weigh chair scale without assistance from another staff member.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 395278
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on February 25, 2025, at 11:30 a.m. revealed resident R67 wearing a brace on his right lower leg and complaining that it was bothering him. He indicated that they had just fixed it, but all they did was glue it.</p> <p>Review of Resident R67's clinical record revealed that she was admitted on [DATE], with diagnoses of abnormalities of gait (pattern of walking) and mobility. Further review revealed a physical therapy note indicating a check on the right foot AFO (ankle foot orthodic, a support to control the position and motion of the ankle) due to complaints of irritation on the back of the resident's right lower leg. A review of the care plan for Resident R67 revealed no plan of care for the AFO.</p> <p>Interview with the Director of Nursing on February 27, 2025, at 2:35 p.m. confirmed that Resident R67 had no care plan for the AFO being used on his right foot.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38735</p> <p>Based on observations, interviews with resident and staff and clinical record review, it was determined that the facility failed to obtain a physician's order regarding the use of an AFO (ankle foot orthodic, a support to control the position and motion of the ankle) and failed to clarify a physician's order pertaining to a resident's alcohol consuption for two of twenty- one residents reviewed (Resident R67 and R4).</p> <p>Findings include:</p> <p>Observation on February 25, 2025, at 11:30 a.m. revealed Resident R67 wearing a brace on his right lower leg and complaining that it was bothering him. He indicated that they had just fixed it, but all they did was glue it. He then pulled out an old brace that he said fit much better.</p> <p>Review of Resident R67's clinical record revealed that she was admitted on [DATE], with diagnoses of abnormalities of gait (pattern of walking) and mobility. Further review revealed a physical therapy note indicating a check on the right foot AFO due to complaints of irritation on the back of the resident's right lower leg. A review of physician orders for Resident R67 revealed no physician order for the AFO.</p> <p>Interview with the Director of Nursing on February 27, 2025, at 2:35 p.m. confirmed that Resident R67 had no physician order for the AFO being used on his right foot.</p> <p>Review of the facility's undated policy, Alcoholic Beverages, indicated that a physician's order obtained that residents may have alcoholic beverages, and that the Nurse Supervisor receiving the order must contact the pharmacist to determine if any of the resident's current medications would interact with alcohol. Continued review of the policy indicated that should there be a medication that would interact with the alcohol, the Nurse Supervisor must inform the physician of such medication.</p> <p>Review of the February 2025 physician orders for Resident R4 included diagnoses of hypertension (high blood pressure); history of falling; depression (major loss of intrest in pleasurable activities); multiple sclerosis (slow progressive diease of the central nervous system); heart failure.</p> <p>Review of February 2025 physician orders included a physician's order dated September 19, 2019, and every month thereafter stating that Resident R4 could have alcoholic beverages. ALCOHOLIC BEVERAGE - May have wine. Continued review of the physician's order did not indicate if there was a specific amount of wine the resident could have and how often she could have it. Continued review of the resident's Medical Administration Record (MAR-documentation by nursing staff when a medication has been administered), and Treatment Administration Record (TAR-documentation by nursing staff when a treatment has been administered to a resident) did not include a section on either of the administration records that where nursing staff would document that the resident had wine any time it was given to her by nursing staff.</p> <p>During an interview with Resident R302 on February 28, 2025 at 12:40 p.m. the resident reported that she is served wine at least once a week on Fridays.</p> <p>(continued on next page)</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>During an interview with Employee E11 (unit manager) on February 28, 2025 at 12:36 p.m., Employee E11 confirmed that the physician's order did not clarify that amount of wine that Resident R4 could have, and that she would check with the physician.</p> <p>28 Pa. Code:201.18(b)(1)(3) Management</p> <p>28 Pa. Code:211.12(d)(1)(5) Nursing services</p>		

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<p>F 0689</p> <p>Level of Harm - 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> 38947</p> <p>Based on staff interviews, review of the clinical record and facility documentation, it was determined the facility failed to ensure a resident was properly monitored and assessed during a hot pack treatment. This failure resulted in actual harm to Resident R302 who sustained a burn on the right shoulder (Resident R302).</p> <p>Findings include:</p> <p>Review of the facility's undated policy, Commercial Hot Packs/Thermal Agent Treatment, indicated the rehabilitation therapist will follow established techniques when applying commercial hot packs as a treatment modality. Further review of the policy indicated the packs are stored in a thermostatically controlled cabinet in water at a temperature of 150-170 degrees Fahrenheit.</p> <p>Continued review of the policy indicated that prior to the application of the commercial hot packs, a physician's order will be obtained and the resident will be evaluated for any contraindications or precautions, as well as all risk and benefits are clearly communicated to the resident.</p> <p>Continued review of the above policy stated the following:</p> <p>Check area every 5-10 minutes after moist heat pack has been applied</p> <p>j. Remove pack after treatment, dry gently and inspect area for any unusual signs</p> <p>k. Discard wet linen according to facility protocol and return moist heat pack to hydrocollator (stainless-steel therapeutic liquid heating device. It is used to heat bentonite-filled cloth heating pads, which are placed on patients to achieve rapid heat for specific body muscle groups. The hydrocollator heats the pads up to 175 F. The unit contains a wire rack to prevent contact of the packs with the bottom of the tank)</p> <p>l. Treatment time should be 15-25 minutes. Residents should be checked every 5-10 minutes for signs of skin irritation and burning.</p> <p>Consideration should be taken when using commercial hot packs with individuals who demonstrate:</p> <p>a) Sensory impairment (e.g., diabetes, CVA (cerebral vascular accident), neuropathies (damage to one or more nerves), nerve root impairment)</p> <p>b) Circulatory impairment (e.g., arteriosclerosis (the thickening and hardening of the walls of the arteries), venous insufficiency, phlebitis (inflammation of a vein)</p> <p>c) Cancer</p> <p>d) Very young/very old resident</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>e) Skin rashes</p> <p>Review of the user manual for Hydrocollator M-2m Mobile Heating Unit utilized by the facility revealed under section titled Safety Precaution indicated, Treatment time should not exceed 30 minutes; Always wrap the HotPac with a towel or [NAME] cover before handling or applying to patient; Constantly monitor the HotPac application to ensure that the skin is not becoming too hot. The Safety Precaution' section also indicated that damage to an individual's skin can occur from exposure to extreme heat or cold, and that the individual applying the treatment should note instructions for proper use.</p> <p>Continued review of the Safety Precaution section indicated the HotPac should not be applied over sensitive skin or in the presence of poor circulation and that individuals with circulatory problems should consult with a physician before using this product.</p> <p>During observation conducted on February 25, 2025 at 2:30 p.m. the Hydrocollator was observed in a room in the therapy department. During the above observation accompanied by the Director of Rehabilitation (Employee E5), it was reported the rehabilitation department has not utilized the unit since November 2024.</p> <p>Review of Resident R302's November 2024 physician orders revealed the resident diagnoses of Anemia Hyperlipidemia (high cholesterol); Hypertension (high blood pressure), and Diabetes (disease characterized by high blood sugars).</p> <p>Review of Resident R302's physician documentation dated November 8, 2024 at 12:48 p.m. revealed Resident R302 was admitted into the facility on [DATE], for rehabilitation services after being treated at a local hospital from October 28, 2024 through November 6, 2024 for a right lower extremity hematoma. The resident was also treated for an elevated INR (International Normalized Ratio- a measure that of how long it takes for an individual's blood to clot).</p> <p>Review of Resident R302's nursing note dated November 22, 2024 at 3:03 p.m. revealed the resident was discharged home on the above referenced date.</p> <p>Review of information submitted to the State Survey Agency on November 13, 2024 revealed, on the morning of November 13, 2024, Resident R302 complained that his/hers shoulder was irritated.</p> <p>Continued review of the information submitted to the State Survey Agency indicated the resident notified the licensed nurse, (Employee E6), who found a burn-like area on (his/hers) right shoulder. The resident told the nurse that his/hers shoulder was stiff at therapy the day prior (November 12, 2024) and that he/she requested heat therapy, which was applied to him/her.</p> <p>Review of a written statement from licensed nurse, Employee E6 dated November 13, 2024 revealed the resident reported to the nurse that his/hers should has [sic] something irritating him. Employee E6 reported that he/she unsnapped the resident's gown and that she saw open skin area to his/hers right shoulder. Employee E6 reported in her statement that the resident told her that while he/she was at therapy the towel was to hot. Employee E6 statement indicated that she notified the wound nurse, unit manager and therapy. Made wound nurse UM (unit manager) Therapy aware.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R302's nursing note by licensed nurse, Employee E6 dated November 13, 2024 at 12:38 p.m. indicated Nurse came to residents room to give morning medication today. Resident reported to nurse that (his/hers) right shoulder is irritated. Nurse asked to look at the shoulder. Upon unsnapping the hospital gown the nurse noticed open area to right shoulder and small blister side by side of each other. Resident explained yesterday 11/12/24 (he/she) felt a draft in his/her room while sitting in the recliner in (his/hers) room by the window, which made (his/hers) shoulder (right) achy. (He/she) goes on to explain (he/she) had therapy yesterday around 2pm where (he/she) rec'd heat to the right shoulder and that the towel was put on (his/hers) shoulder for the shoulder pain. Nurse ask was the towel hot. Resident said the towel was wet and started to get hot. Nurse said ok. Wound nurse, Unit manager and Therapy made aware.</p> <p>During an interview with licensed nurse, Employee E6 on March 3, 2025 at 12:45 p.m. Employee E6's statement and nursing notes regarding the incident were reviewed and confirmed.</p> <p>Review of a nursing note from the wound nurse, Employee E7 dated November 13, 2024, at 10:48 a.m. indicated that she was notified by nurse of injury to right shoulder. Resident was in therapy yesterday receiving heat therapy to right shoulder, nurse noted this morning a burn-like area. Area presents 2.5cm (centimeters) x 2.0cm, 100% pale pink tissue, no drainage, periwound intact, adjacent intact blister 0.3cm x 0.5cm, no drainage. Appears as scar tissue that experienced sensitivity to heat source and had mild reaction when heat was applied. Cleansed area with NSS (normal saline solution), applied Vaseline and covered with foam dressing. All appropriate parties notified. Orders and care plan updated.</p> <p>During an interview with the wound nurse, Employee E7 on March 3, 2025, at 12:39 p.m. Employee E7's notes, including the treatment provided, description of the injured areas, including the size of the injured areas, was reviewed and confirmed with the wound nurse.</p> <p>Review of an undated written statement from Employee E9 (Physical Therapy Assistant-PTA) indicated the resident requested the hot pack treatment to (his/hers) right shoulder at the end of physical therapy treatment due to pain, and the PTA attended to and observed the resident during the treatment. The PTA wrote in his statement that he asked the resident multiple times if the heat felt ok, and the resident reported that it felt fine and that (resident) was without complaints. The PTA reported the resident had two layers of clothing on (his/hers) shoulder and that the hot packs were covered in wrap plus one folded towel and one extra towel.</p> <p>Physical Therapy Assistant, Employee E8 was terminated on November 13, 2024, the day after the incident occurred, and was not available for an interview.</p> <p>During an interview with the physical therapist (Employee E10) on February 28, 2025 at 1:32 p.m. it was confirmed the incident occurred on November 12, 2024 and the treatment utilizing the hotpack took place in the therapy department. When asked if the treatment the resident received from Employee E9 was an authorized treatment, Employee E10 reported the treatment modality was not authorized in the resident's plan of care with the therapy department, and the PTA did not ask a physical therapist if it was permitted to provide Resident R302 with this treatment modality. Resident's plan of care was reviewed with the physical therapist and it did not include the use of the hotpacks.</p> <p>(continued on next page)</p>		

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>Continued interview with physical therapist, Employee E10 revealed the PTA did not document the treatment modality with the hotpacks, as required by therapy department. There was no documentation the PTA observed the skin areas that were being treated during the treatment or after the treatment, or how long the treatment actually occurred, due to the absence of clinical documentation.</p> <p>The facility failed to ensure that Resident R302 was properly monitored and assessed by physical therapist staff during the administration of a hot pack treatment which resulted in actual harm to Resident R302 who sustained a burn on the right shoulder.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>38735</p> <p>Based on observations and interviews with staff, it was determined that the facility did not ensure that that trash and recyclables were properly disposed of in the receiving and dumpster area.</p> <p>Findings include:</p> <p>A tour of the Food Service Department was conducted on February 25, 2025, at 9:30 a.m. with Employee E3, Dining Operations Manager (DOM), revealed the following concerns:</p> <p>Observations in the receiving area revealed the trash compactor with the metal door ajar and the bags of trash inside exposed. Further observations revealed the cardboard recycling dumpster with two of the sliding doors open and the can recycling dumpster with both top doors open and the side sliding door open.</p> <p>Observation near the receiving door revealed four wooden pallets laying on the ground with broken pieces of splintered wood scattered around on the ground, three large grey trash cans laying on the ground, two large blue laundry bins half filled with rain water and trash including a broken hot holding pan warmer.</p> <p>Interview with the DOM on February 25, 2025, at 9:30 a.m. confirmed the above findings.</p> <p>28 PA Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(3) Management</p>		