STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395338	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Immaculatemarycenter for Rehabilitation&healthcare	2990 Holme Avenue Philadelphia, PA 19136

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 41471 Based on the review of clinical records, facility documentation, facility policies, and interviews with resident and staff, it was determined that the facility failed to demonstrate evidence that a resident/resident representative grievance was promptly documented, and resolved for one of three resident records reviewed and failed to ensure that the grievance policy inlcuded all the required components. (Resident R1) Findings Include: Review of facility policy Grievance/Concern Recording and Investigation revised 09/2023 revealed Grievances/concerns filed with the facility will be investigated and actions will be taken to resolve the grievance/concerns. Policy Interpretation and Implementation: The Administrator has assigned the responsibility of investigating grievances/concerns to the department director or designee. Upon receiving a grievance/concern report, the department director or designee will begin an investigation into the grievance/concern. If the grievance/concern cannot be addressed timely, a written grievance/ concern will be documented on a concern log for further follow-up. The department director(s) of any named employee(s) will be notified of the nature of the grievance/concern that an investigation is underway. The resident, or person acting on behalf of the resident, will be informed of the findings of the investigation of a grievance/concern. The administrator will coordinate actions with the appropriate state and federal agencies, depending on the nature of the grievance/concern. Continue review of the grievance policy revealed that the policy failed to include that the facility is to track all grievances, to ensure the documentation of grievance decision, and a summary statements of all grievance. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with facility Administrator on April 17, 2024, at 2:00 p.m. stated facility did not document all grievances from residents, or resident representatives. Administrator stated facility only initiated written greivance when a grievance/concern was not able to be address quickly. Administrator also confirmed that the above-mentioned policy was the only facility grievance policy, no other policy was available related to facility grievance process. Interview with resident representative and resident on April 17, 2024, at 1:00 p.m. stated facility did not provide appropriate diet for the resident. She was provided food that she was not able to chew. Resident representative also stated she was not given enough food; she should have received double portion and facility often did not provide the food. Resident representative stated she reported this concerns multiple times to the facility staff but did not resolve the issue or received a response from the facility. Review of a physician progress note dated March 23, 2024, revealed that the resident was asking for more food, resident had double portion ordered but resident stated it was not enough. Interview with Employee E4, Nursing unit coordinator, on April 17, 2024, at 1:34 p.m. stated resident and representative did mention about not receiving double portion as ordered. Employee E4 stated he did not initiate a grievance about this, but he verified if she was getting appropriate quantity of food. Interview with facility Administrator on April 17, 2024, at 2:00 p.m. confirmed that the facility did not have a documented concern/grievance from Resident R1 or representative related to not receiving food as ordered. 28 Pa. Code 201.18 (b)(1)(3)(2.1)(4) Management 28 Pa. Code 201.29 (a) Resident Rights

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 41471 Based on review of facility's policies, review of clinical records and staff interviews, it was determined that the facility failed to ensure that an alleged violations involving resident neglect was reported to the State Survey Agency (Department of Health) as required for two of three residents reviewed (Resident R1 and Resident R2). Findings include: Review of the facility policy titled, Abuse Prevention/Reporting revised, December 12, 2023, revealed, Neglect - the failure of a facility, its employees or services providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. ABUSE means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. The facility will report all alleged violations involving mistreatment, neglect or abuse to the Department of Health, Division of Nursing Facilities, and to other agencies required by law and Act 13 (Ombudsman. Police, Department, Department of Aging Services, Protective Services and/or the Attorney General). The facility will conduct an investigation of all suspected cases of abuse. The final report will be completed and sent to the respective agencies. The procedure for investigation, results, and corrective action must be included in the report. Bulletin #22 will be submitted to DOH for suspected and actual cases of resident abuse. Review of grievance dated April 1, 2024, by Resident R1 revealed that the resident reported that the nurse aide did not assist her while in the bathroom. She stated she called her daughter to come and get her. Interview with resident representative and resident on April 17, 2024, at 1:00 p.m. stated staff did not provide care to the resident on April 1, 2024, around 2 a.m. She stated staff put resident in the bathroom, did not return to assist her, did not answer the call bell in a timely manner and when one staff came to answer call bell after long time, she refused to provide care. Resident representative stated she went into the facility in the middle of the night to assist the resident. Review of facility grievance dated April 8, 2024, revealed that Resident R2's daughter reported concern related to the care, resident was unhappy with weekend care, call bell response time, male staff not to enter room or provide care and resident wanted to go home. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of social service statement dated April 8, 2024, revealed that the social worker met with Resident R2 and her family. Family reported that they have been unhappy with the care provided on 3-11 and 7-3. Review of a statement from dietician dated April 8, 2024, revealed that at the time of care conference resident and family members informed that they would be taking resident home, they were dissatisfied with the over nigh care. Review of facility reported incident revealed that the above allegation was not reported to the State Survey Agency as required. Interview with the Nursing Home Administrator on April 17, 2024, at 2:00 p.m. confirmed that the allegation of resident neglect for Resident R1 and Resident R2 was not reported to the Department of Health. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 201.18(e)(1) Management.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 41471 Based on review of clinical records, facility policies and interviews with staff, it was determined that the facility failed to conduct a complete and thorough investigation of improper resident care for one of three residents reviewed. (Resident R2). Findings include: Review of the facility policy titled, Abuse Prevention/Reporting revised, December 12, 2023, revealed, Neglect - the failure of a facility, its employees or services providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. ABUSE means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. INVESTIGATION: All claims should immediately be investigated as per policies and procedures. Residents and family members will be informed of the complaint, the investigation, and actions taken as a result of the investigation. 1. The following is a list of methods to be used to conduct investigation: a. Review of records; b. Observe and interview residents, staff members, accused personnel, witnesses, family members, visitors; c. Compile written documentation which includes signed witness; statements, statement of accused personnel, medical records, incident reports and other pertinent information; d. Review of employee work schedules; e. Observe social media posts. 2. All incident reports are reviewed and analyzed to identify patterns according to shifts, type of incident, resident, and numbers of incident; staff involved and care givers for past 24 hours. 3. In the event of misappropriation of property, a thorough search of the building is conducted to determine possible misallocation of missing items. A Missing Item Form is completed and missing items are analyzed for patterns, location and care givers. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. In the event of a suspicious incident (i.e. death, fall), the immediate environment should not be disturbed until proper authorities are notified and arrive (i.e. Police, Administrator, Medical Director, Coroner, Department of Health, Office of Aging). 5. Bulletin #22 will be utilized for reporting all suspected and actual cases of abuse involving any staff member. 6. All incidents involving abuse will be analyzed to determine root cause and to identify ways to prevent reoccurrence of the incident. Review of facility grievance dated April 8, 2024, revealed that Resident R2's daughter reported concern related to the care, resident was unhappy with weekend care, call bell response time, male staff not to enter room or provide care and resident wanted to go home. Further review of the investigation revealed no documented evidence that the facility ontained written statements from resident or representative related to specifics of the allegation Review of social service statement dated April 8, 2024, revealed that the social worker met with Resident R2 and her family. Family reported that they have been unhappy with the care provided on 3-11 and 7-3. Review of a statement from dietician dated April 8, 2024, revealed that at the time of care conference resident and family members informed that they would be taking resident home, they were dissatisfied with the over nigh care. Review of assignment sheet/staffing sheet of the facility revealed that there were eight nurses' aides worked on the unit on 4/6/24 and 4/7/24 for all three shifts. Facility staffing sheet revealed that there was two LPNs assigned on the unit for day and evening shift and one for the night shift. There was only four staff interviews and one supervisor statements included in facility investigation. Interview with the Director of Nursing on April 17, 2024, at 2:00 p.m. confirmed that the facility did not obtain witness statement from all staff who worked on the unit. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management.