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	10/03/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record, facility policies, facility documentation, and interviews with staff, it was determined the facility failed to provide adequate supervision for one of 13 residents reviewed (Resident R1). This failure resulted in Resident R1 exiting the third-floor lockdown unit, accessing the elevator to the lobby, and walking out the front entrance of the facility. Resident R1 was located approximately two hours later at a family members residence, approximately 1.2 miles away from the facility. Resident R1 accessed a busy traffic area. This failure placed the resident at high risk for injury and was identified as an Immediate Jeopardy situation. (Resident R1) Findings include: Facility policy titled Residents at Risk for Elopement/ Elopement process, revised 2025, revealed on admission nursing personal will complete an elopement evaluation and thereafter routinely for residents. If a resident is deemed at risk for elopement, nursing staff will care plan the resident for being at risk for elopement. Further review of facility policy revealed if an employee observes a resident leaving the premises, he/she should:a. Attempt to prevent the departure in a courteous manner;b. Get help from other staff members in the immediate vicinity, if necessary; andc. Instruct another staff member to inform the Charge Nurse or Director of Nursing Services that a resident has left the premises. Review of Resident R1's clinical record revealed that the resident was admitted on [DATE], with a diagnosis of Dementia (loss of cognitive functioning that interferes with daily life and activities), muscle weakness, and Major Depressive Disorder. Review of Resident R1's care plan, dated September 24, 2025, revealed Resident R1 was at risk for falls due to dementia. Continued review of the care plan revealed Resident R1 has impaired cognitive function related to dementia. Review of Resident R1's occupational therapy (OT) initial assessment, dated September 24, 2025, revealed the resident was referred to OT due to new onset of decrease in strength, decrease in functional mobility, and reduced activities of daily living (ADL) participation. Further review of Resident R1's occupation therapy initial assessment revealed Risk factors: due to documented physical impairments and associated functional deficits the patient is at risk for: falls and further decline in function. Review of Resident R1's elopement evaluation, dated September 23, 2025, revealed the resident was not at risk for elopement. Further review of the same elopement assessment it was noted the assessment was inaccurately coded and indicated the resident was not cognitively impaired or had a diagnosis of dementia. Review of facility reported documentation submitted to the department, dated September 26, 2025, revealed on September 23, 2025, Resident R1 was admitted to the third floor (secure unit). Resident R1 is able to make (his/her) needs known. Prior to [Resident R1] leaving the facility (he/she) was noted in bed Based upon investigation, it was determined [Resident R1] with the assistance of dietary staff, utilized the elevator to go to the first floor. Due to [Resident R1] presentation the front desk staff believed (he/she) was a visitor and exited the facility. The staff were informed of resident's absence when resident's granddaughter called to report incident to facility. Review of facility investigation, dated September 26, 2025, revealed the facility became aware of eloped resident via phone call from Resident R1's family member stating the resident went to his/her granddaughter's house. The resident exited the facility without the knowledge of staff. Resident consumed dinner and medication for the evening prior to the elopement. Resident R1 retuned to the facility with family member. Interview with Administrator, Employee E1 on October 03, 2025 at 9:30 a.m. revealed Resident R1 left the facility at 7:16 p.m. and returned to the facility at approximately 9:15 p.m. Review of a statement from Charge Nurse, Employee E16, revealed he/she saw Resident R1 in his/her room around 7:00 p.m. on the night of the elopement. Review of statement by Nursing Aide, Employee E19, revealed resident was assisted to bed and reeducated how to use the remote control for the television around 7:15 p.m. on night of elopement. Review of a statement by receptionist, Employee E17, revealed he/she was on duty when the resident exited the facility. The resident exited the facility at approximately 7:30 p.m. The resident was dressed in clothing that did not match typical resident attire nor have any identifying med bands and therefore did not appear to be a resident at first. The resident said, 'have a good night and have a good one.' The employee was unaware the resident left the facility until the facility when got the call after 9:00 p.m. Review of statement from dietary staff, Employee E18, revealed the employee was collecting carts off the 3rd floor nursing unit. A woman, who he/she did not recognize as a resident, came through the doors with him/her and went into one of the elevators. Interview conducted with Dietary Director, Employee E5, on October 03, 2025, at 11:39 a.m. revealed prior to Resident R1's elopement the dietary staff were able to use any available elevator during meal service. Since Resident R1's

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (continued on next page)

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of job descriptions, facility documentation, and interviews with staff, it was determined that the Nursing Home Administrator and Director of Nursing failed to effectively manage the facility to ensure that adequate supervisor was provided to one of 13 residents reviewed (Resident R1). This failure resulted in Resident R1 exiting the third floor locked down unit via elevator and walking out the front entrance of the facility. Resident R1 was located approximately two hours after the resident exited the facility approximately 1.2 miles away from the facility. Accessing high traffic areas and busy intersections. This failure placed the resident at high risk for injury and was identified as an Immediate Jeopardy of past non-compliance. (Resident R1) Findings include: Review of the job description of the Nursing Home Administrator (NHA) revealed that, the primary purpose of the job position is to direct the day-day-day functions of the Center in accordance with current federal, state, and local standards, guidelines and regulations that govern long term care facilities to assure that the highest degree of quality of care can be provided to the residents at all times. As Administrator, you are delegated the administrative authority, responsibility and accountability necessary for carrying out your assigned duties. Review of the job description of the Director of Nursing (DON) revealed that, the primary purpose of the job description is to plan, organize, develop and direct the overall operation of our Nursing Service Department in accordance with current federal, state, and local standards, guidelines and regulations that govern the facility, and as may be directed by Administrator and the Medical Director, to ensure that the highest degrees of quality care is maintained at all times. Review of Resident R1's clinical record revealed that the resident was admitted on [DATE] with a diagnosis of dementia (loss of cognitive functioning that interferes with daily life and activities), muscle weakness, and major depressive disorder. Review of Resident R1's care plan, dated September 24, 2025, revealed Resident R1 was at risk for falls due to dementia (confusion). Continued review of the care plan revealed Resident R1 has impaired cognitive function related to dementia. Review of Resident R1's occupational therapy initial assessment, dated September 24, 2025, revealed the resident was referred to OT due to new onset of decrease in strength, decrease in functional mobility, and reduced activities of daily living (ADL) participation. Further review of Resident R1's occupation therapy initial assessment revealed Risk factors: due to documented physical impairments and associated functional deficits the patient is at risk for: falls and further decline in function. Review of facility reported documentation submitted to the Department of Health, dated September 26, 2025, revealed on September 23, 2025 Resident R1 was admitted to the third floor (locked unit). Resident R1 is able to make her needs known. Prior to resident leaving the facility he/she was noted in bed. Nursing staff were unaware of an elopement history of resident prior to coming to the facility. Based upon investigation, it was determined the resident with the assistance of the dietary staff, exited locked unit and utilized the elevator to go to the first floor. Due to the resident's presentation the front desk staff believed he/she was a visitor and opened door for resident to exit the facility. The staff were informed of resident's absence when resident's granddaughter called to report incident to facility. Review of facility investigation, dated September 26, 2025, revealed the facility received phone call from Resident R1's family member stating the resident went to his/her granddaughter's house. The resident exited the facility without the knowledge of staff. Resident consumed dinner and medication for the evening prior to the elopement. Resident R1 returned to the facility with family member. Interview with Administrator, Employee E1 on October 03, 2025 at 9:30 a.m. revealed Resident R1 left the facility at 7:16 p.m. and returned to the facility at approximately 9:15 p.m. Review of a statement from receptionist, Employee E17, revealed he/she was on duty when the resident exited the facility. The resident exited the facility at approximately 7:30 p.m. The resident was dressed in clothing that did not match typical resident attire nor have any identifying med bands and therefore did not appear to be a resident at first. The resident said, have a good night and have a good one. The employee was not aware that the resident left until the facility when got the call after 9:00 p.m. Review of a statement from dietary staff, Employee E18, revealed the employee was collecting carts off the floor. A woman, who he/she did not know was a resident, came through the doors with him/her and went into one of the elevators. Interview with Receptionist, Employee E3, on October 03, 2025 at 10:15am, revealed the process prior to the elopement involved visitors using a machine, located outside of door in entry way, to sign in. Employee stated that prior to elopement there was no process in place to sign out visitors. Review of internet maps revealed that the house in which the resident was located after elopement was 1.2 miles away from the

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and interview with staff, it was determined that the facility failed to ensure that an elopement risk assessment was accurate for one of 13 residents reviewed (Resident R1). Findings include: Review of Resident R1's clinical record revealed that the resident was admitted on [DATE] with a diagnosis of dementia (loss of cognitive functioning that interferes with daily life and activities), muscle weakness, and major depressive disorder. Review of Resident R1's care plan, dated September 24, 2025, revealed the resident has impaired cognitive function related to dementia. Review of Resident R1's elopement evaluation, dated September 23, 2025, revealed the resident was not at risk for elopement. Further review of the same elopement assessment it was noted the assessment was inaccurately coded and indicated the resident was not cognitively impaired or had a diagnosis of dementia. Interview on October 03, 2025 at 11:15 a.m. with Employee E4, Licensed Practical Nurse, confirmed the resident elopement assessments should be based on whether the resident can or can not make their own decisions and if they have past diagnosis or behaviors. 28 Pa. Code 211.5(f)(ix) Medical records 28 Pa. Code 211.12(d)(1) Nursing services