STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395342	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hopkins Center	8100 Washington Lane Wyncote, PA 19095

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38947 Based on staff and resident's responsible party interview and review of clinical records, it was determined that the facility failed to ensure that advanced notice was provided to the resident and his emergency contact of care plan meetings and failed to ensure that care plan meetings were held in a timely manner for 3 out of 3 residents reviewed (Resident R1, R2 and R3). Findings include: Review of Resident R1's person-centered plan of care indicated that the resident had impaired thought processes related to diagnosis of dementia. Review of a nursing note dated November 22, 2024 at 7:27 a.m. documented that the resident was disoriented and required cues. Review of a nursing note dated November 22, 2024, at 11:33 p.m. documented that the resident was confused and required cues. The note also documented that the resident had a wander guard (a device that is placed on an individual's wrist or ankle, who has been identified as an elopement risk, and alerts staff when the resident is an area that is not safe) on his left ankle. Review of a note dated November 26, 2024 at 11:35 a.m. by the facility's physiatrist nurse practitioner (physiatrist- medical doctor who can diagnosis the cause of pain and develop a comprehensive treatment plan) providing treatment to the resident at that [NAME] documented that the resident was pleasantly confused during the visit. During an interview on January 6, 2024 at 9:12 a.m. the resident's emergency contact reported that Resident R1 received care at the facility, but that was never any meeting held that she was invited to regarding his care. The resident's emergency contact reported that the only update that she received was when she would visit the resident after work in the evening and they would tell her, he had a good day, or he took all his medications. The emergency contact reported that she asked the nurses on several occasions to have the Medical Director (Employee E5) so that she can get an updated on how he was doing, but that the physician never call The emergency contact reported that at one point, she contacted the therapy department, had a meeting and training with the therapy department and the Social worker (Employee E8) regarding his progress, and schedule his discharge date was set for December 24, 2024. (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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	395342	A. Building B. Wing	01/09/2025

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's nursing notes indicated that on November 24, 2024, at 10:23 a.m. indicated that the resident's care plan meeting took place, and that the resident, social services and the nurse unit manger were present. Continued review of the care plan note and clinical notes did not indicate that the resident's emergency contact was notified of the meeting or had the opportunity to participate. During an interview with the social worker (Employee E8) on January 8, 2024 at 2:00 p.m. the social worker reported that care plan meeting are held on Tuesdays and Thursday and that he contacts the responsible parties for the care plan meetings only if the resident is not alert or oriented. The social worker was asked how far in advance does he contact the responsible party regarding the care plan meeting, and reported that if he does not have time he contacts them the day before the care plan meeting is scheduled to occur. The social worker reported that if the resident is alert and oriented, he meets with the resident in their room. He reported that he does not ask the alert and oriented resident if there is someone that he/she wanted to invite to their meeting. It was discussed during the interview that there was no evidence that resident R1's emergency contact was invited to the care plan meeting on November 27, 2024. Review of the clinical record for Resident R2 included a social services note dated January 7, 2025 at 1:16 p. m. that plan of care meeting was held on January 7, 2025. Continued review of the clinical record for the 2 prior care plan meeting that the resident should have had showed no evidence that the facility conducted those meetings. Review of thee clinical record for Resident R3 included a social services note dated May 2, 2024 at 11:02 a. m. indicating that a care plan meeting took place. Continued review of the clinical reecord included no additonal care plan meeting conducted by the facility for the resident since that date. During an interview with the resident on January 9, 2024 at 1:58 p.m. the resident reported that she had not had a care plan meeting in a while, and that she did not remember the last time that she had one. During an interview with the social worker (Employee E8) on January 8, 2024 at 2:00 p.m. the social worker reported that there are care plan meetings that are late, and have not been held. During an interview with the Regional Nurse, Nursing Home Administrator and the Director of Nursing on January 9, 2024 at 5:15 p.m. it was confirmed by the Regional Nurse that no additional informaition can be produced to show evidence that care plan meetings were being held for residents in a timely manner. 28 Pa. Code 201.29(c.3)(1) Resident rights 28 Pa Code 211.11(d) Resident care plan 28 Pa. Code 211.12(c(1))Nursing services 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38947 Based on staff and resident's emergency contact interviews, review of faciltiy policy and review of clinical records, it was determined that the facility failed to ensure that documented room change notifications to the resident and emergency contact were provided for 1 out of 7 residents reviewed (Resident R1). Findings include: Review of the facility policy, Room Changes, with a revision date of January 25, 2024, indicated that Notification of room change of new roommate will be provided within reasonable/required time when necessary. Continued review of the policy also indicated that social services or designee will process and coordinate all request for room changes in accordance with state and federal guidelines. Continued review of the policy indicated that if the room change is patient initiatived, the facility will discuss the move request with the patient and/or patient representative and appropriate staff. Review of the December 2024 physician orders for Resident R1 indicated that the resident was admitted into the facility on [DATE] with diagnoses of history of falling; heart failure (the heart muscles don't pump as much blood as they should); atrial fibrillation (an irregular and very rapid heart rhythm; diabetes (a condition in which the body has high blood sugars for prolonged periods of time); dementia (group of symptoms affecting memory, thinking and social abilities; cognitive communication deficit (impaired functioning with attention, memory, organizations, problems solving and reasoning); post-traumatic stress disorder (PTSD-a mental health condition caused by an extremely stressful or terrifying event); psychotic disturbance (mental health illness characterized by being diassociated from reality) and mood disturbance (a mental health condition that can cause persistent and intense sadness, elation and or anger). Review of the resident person-centered plan of care indicated that the resident had impaired thought processes related to his diagnosis of dementia. Review of a nursing note dated November 22, 2024 at 7:27 a.m. documented that the resident was disoriented and required cues. Review of a nursing note dated November 22, 2024, at 11:33 p.m. documented that the resident was confused and required cues. The note also documented that the resident had a wander guard (a device that is placed on an individual's wrist or ankle, who has been identified as an elopement risk, and alerts staff when the resident is an area that is not safe) on his left ankle. During an interview with the resident's emergency contact on January 6, 2025 at 9:12 a.m. the emergency contacted reported that the resident's room was changed from room [ROOM NUMBER] (2nd floor) to room [ROOM NUMBER] (3rd floor), and that she was not notified of the room change. The emergency contact reported that she came to visit the resident in room [ROOM NUMBER] on the date that the room change occurred, did not see him in his room, and was told that he had been transferred to another floor due to a female resident using the bathroom that he used. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of nursing noted dated November 27, 2024 at 1:38 p.m. indicating that a room transfer took place for the resident. During a discussion with the Regional Nurse (Employee E3) and the Nursing Home Administrator (NHA) on January 8, 2025 at 3:19 p.m. the reason as to why the resident' room was changed could not be provided by the facility, as various reasons were provided during the interview (e.g. he was moved because the resident was long term care; he was moved so that he could have a roommate that was more compatible). It was also discussed during the above referenced interview that there was no indication that the resident and his emergency contact were provided with written prior notification of the room change explaining why the room change needed to take place, in addition to other required procedures/steps took place prior to a room change occurring. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.29(c.3) (1) Resident rights

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38947 Based on staff interviews, review of facility policy and review of the clinical record, it was determined that the facility failed to develop and implement an effective discharge planning process for 1 out of 2 residents reviewed for this care area (Resident R1). Findings include: Review of the facility policy Discharge Planning Process, with a revision date of November 15, 2022 indicated that the facility must implement an effective discharge planning process that focuses on the patient's/resident's/ discharge goals, the preparation of patients to be active partners and effectively discharge them to post-discharge care, and the reduction of factors leading to the reduction of factors leading to preventable readmissions. Continued review of the policy indicated that the facility's discharge planning process will include, involving the patient and resident representative in order to establish goals of care and treatment preferences; recommending options for the continuing care of the patient; referring the patient to programs or services that meet the patient's assessed needs and preferences; ensuring that there is documentation that the resident has been asked about his/her interest in receiving information about returning to the community and if interested, documenting any referrals to local contact agencies or other appropriate entities made for this purpose and also updating a patient's care plan and discharge plan as appropriate in response to information received from referrals to local contact agencies of appropriate entities, Review of Resident R1's person-centered plan of care indicated that the resident had impaired thought processes related to his diagnosis of dementia. Review of a nursing note dated November 21, 2024 at 11: 28 p.m. indicated that the resident was admitted into the facility on the above referenced date for rehabilitation services. Review of a nursing note dated December 24, 2024, at 7:11 p.m. indicated that the resident was discharged from the facility and transported back to his home. Review of the December 2024 physician orders included a physician's orders for Bumetanide 1 milligram tablet by mouth once a day for heart failure, Metoprolol Succinate ER Tablet Extended Release 24, for heart failure and hypertension and Haloperidol 0.5-1 milligram tablet by mouth every 12 hours for anxiety and delusions, and Ferrous Sulfate (a supplement used to treat iron deficiency anemia) as a supplement 1-325 milligram tablet by mouth 2 times a day. During an interview with the emergency contact on January 6, 2024 at 9:12 a.m. The emergency contact reported that the resident was scheduled to be discharged on [DATE], and that when he was discharged , the resident needed prescriptions for the medications that he was ordered to take, but that a physician was not available to write prescriptions for those medications, and the facility did not have any medication samples to give her so that the resident could take until a prescription could be fulfilled. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's discharge documents, indicated that the resident was discharged without a prescription for the medications that he needed to take. During an interview with a unit manager (Employee E4) who worked on December 26, 2024, the unit manager reported that the resident's emergency contact called and reported that she still did not have all of the resident's medication, or any prescriptions for the resident and that he was discharged on [DATE] . During the interview, the Unit manager reported that the physician (Employee E4) was at the facility on December 26, 2024 so she contacted him to let him know that the prescriptions needed to be written for the resident's. During an interview with the Medical Director (MD, Employee E5) on January 8, 2025 at 3:00 p.m., he MD reported that he did not know that the resident was scheduled for discharge on December 24, 2024. The MD reported that he received a call at approximately 5:00 p.m. from the facility on December 24, 2024 requesting that he write prescriptions for the medications that the resident was on, and explained that he could not write those prescriptions at that time. The MD reported that he came in on December 26, 2024, wrote all the prescriptions and nursing faxed them over to the pharmacy that he was instructed to send them to. 28 Pa. Code 211.12(c)(1))Nursing services 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38947 Based on observations, staff interviews and review of facility documentation, it was determined that the facility failed to ensure that an effective pest control program and a pest free environment. Findings include: Review of the facility's contract with a local pest control company which began [DATE] indicated that the pest control company services will cover mice, ants, all species of roaches, and stinging insects up to 15 ft high. The pest control company indicated that the services in the contract do not include bed bugs, termites and wildlife. Continued review of the pest control contract indicated that the company will provide services to the facility twice monthly, and that the company will inspect, monitor and treat as needed for the above primary targeted pests, in addition to servicing resident rooms by request, check and date the pest log book in kitchen, and all nursing stations, in addition to other listed tasks during their visit. During an interview with the emergency contact for Resident R1 on [DATE] at 9:12 a.m. that she observed bugs running around the resident's bathroom on several occasions when she would visit. Review of pest control logs on the 2nd floor indicated the following: --[DATE] a bunch of roaches running around --[DATE] roaches noted was written, and the floor pantry in addition to a named hall on the floor were listed as the locations of the roaches. --[DATE] water bugs and roaches all around 221 D Big ones little bugs. Review of the pest control logs on the 3rd floor indicated the following: --[DATE] 2 black bugs --[DATE] 2 black roaches --[DATE] 2 black roaches Review of pest reports from the pest control company from [DATE] through [DATE] indicated that the company provided pest control services to the facility on [DATE]; [DATE]; and [DATE], and indicated the following: --room [ROOM NUMBER] .clutter near nightstand, poor sanitation. Will lead to increase activity for pest. --room [ROOM NUMBER] .observed trash and debris under radiator (continued on next page)

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	395342	A. Building B. Wing	01/09/2025

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--room [ROOM NUMBER] .cluttered perimeter During an observation in room [ROOM NUMBER] on [DATE] at 1:50 p.m. Resident R4's side of the room near the door (221 D) was observed as being covered with food items that consisted of ketchup, a bottle of pancake syrup with the cap half on, in addition to mustard and hot sauce, candy handing out of the night stand drawer, in addition to other items on the residents night stand on the left side of the resident's bed (when facing the resident's bed) and on the residents. The resident's bedside table had food items on it in addition to about 2 cans of soda. The floor in the resident's room appeared soiled. During an observation in room [ROOM NUMBER] for Resident R5 and Resident R6 on [DATE] at 10:34 a.m. several bugs were observed flying throughout the room, debris under the radiator was observed. During an observation on [DATE], at 2:13 p.m. in room [ROOM NUMBER] approximately ,d+[DATE] deceased brown roaches/bugs were observed in a mouse trap that was on the left side of the toilet near the wall. During an observation on Resident R7's side of the room, 2 open milk cartons, coffee creamers and a container of food and other items on the left of his bed (when facing his bed), in addition to 4 Styrofoam cups that were from other dates (one from ,d+[DATE]) with what appeared to be stains on the tops of the lids that were on them. There was another opened milk carton and a closed one on the bed side table. A bowl of uncored peaches was also on the bedside table, in addition to an opened container of what looked like a dried up container of what could have been chocolate ice cream in a small Styrofoam container. In addition, about ,d+[DATE] empty plastic cups were also observed on the resident's bedside table. About ,d+[DATE] more Styrofoam cups were observed on the resident's night stand that was on the right corner of his room next to his bed (when stand facing the resident's bed), in addition to other items on the night stand. Resident had addition items covering his windowsill and heating unit that made the area appear cluttered, in addition to a plastic container filled with various items (books/papers) next to the heating/cooling unit was also observed. Additional styrofoam cups that appeared to be filled with beverage items at one point were observed on the floor on the right of the resident's bed. Two styrofoam cups that were closer to the wall appeared to be filled with a liquid. Other items were also on the floor. There was a smell/stench when you entered the resident's room and the resident's floor was soiled. Resident R7 reported that he sees roaches in his room all of the time, especially in the bathroom. Observations in the above referenced rooms showed now evidence that the recommendations/comments made during the visit on [DATE] were implemented by the facility to ensure a pest free environment for residents. Review of pest control logs on the 2nd floor indicated the following: --[DATE] a bunch of roaches running around --[DATE] roaches noted was written, and the floor pantry in addition to a named hall on the floor were listed as the locations of the roaches. --[DATE] water bugs and roaches all around 221 D Big ones little bugs. Review of the pest control logs on the 3rd floor indicated the following: (continued on next page)

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	395342	A. Building B. Wing	01/09/2025

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--[DATE] 2 black bugs --[DATE] 2 black roaches --[DATE] 2 black roaches During an interview with the Regional Nurse, Nursing Home Administrator (NHA) and the Director of Nursing on [DATE] at 5:15 p.m. it was discussed that from the obervations made in the above referenced room recommendations/comments that the pest control company left after their visit 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(3) Management