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	03/03/2025

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

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344 Based on review of facility policies, clinical record, facility documentation, and interviews with residents and staff, it was determined the facility failed to prevent resident neglect by not following safe resident care guidelines which resulted in harm to Resident R1 who sustained fractures of the left humerus, the spine, and contusion to the right shin for one of seven residents reviewed (Resident R1). Findings include: Review of facility policy titled, Safe Resident Handling Program dated April 15, 2023, revealed, Transfer assistance, mobility, and other resident handling tasks are to be carried out in accordance with the Lift/Transfer Assessment and care plan. Review of facility policy titled Abuse Prohibition, dated October 24, 2022, revealed, Centers prohibit abuse, mistreatment, neglect, misappropriation of resident/patient property, and exploitation for all patients. Continued review revealed, Neglect is defined as the failure, indifference or disregard of the Center, its employees, or service providers to provide care, comfort, safety, goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of Resident R1's Quarterly MDS Assessment (Minimum Data Set - a mandatory periodic resident assessment tool), dated December 9, 2024, revealed the resident was admitted to the facility on [DATE], and had diagnoses of Heart Failure (chronic condition in which the heart doesn't pump blood as well as it should), Respiratory Failure (not enough oxygen passes from the lungs to the blood), Renal Failure (a condition in which the kidneys lose the ability to remove waste and balance fluids), diabetes (ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose), morbid obesity (excess body fat) and Lymphedema (swelling caused by a buildup of fluid in one area of your body, usually an arm or a leg). Continued review revealed the resident had a BIMS (Brief Interview for Mental Status) score of 15, which indicated the resident was cognitively intact. Further review revealed the resident required substantial/maximal assistance for rolling left and right in bed. Review of Resident R1's care plan, dated October 31, 2023, revealed the resident required assistance with activities of daily living care, including bed mobility. A care plan intervention, dated May 23, 2024, revealed the resident required two person assistance with all care. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Continued review of Resident R1's care plan, revealed the resident was at risk for falls related to impaired mobility. Further review of Resident R1's care plan revealed an intervention, dated February 2, 2025, for the resident to have quarter side rails for mobility and repositioning. Review of Resident R1's Lift Transfer Evaluation, dated February 3, 2025, revealed the resident weighed 365 pounds and the resident required extensive/total assistance to turn/reposition in bed of more than two staff. Review of facility documentation, submitted to the Pennsylvania Department of Health on February 11, 2025, at 2:48 p.m. revealed on February 10, 2025, Resident R1 rolled out of bed and fell to the floor while Employee E4, nurse aide, was providing care. Resident R1 was subsequently transferred to the hospital. The hospital evaluation revealed Resident R1 sustained a left humerus fracture (breakage of the upper arm bone) and a T11 wedge compression fracture (breakage of the spine bone between the upper and lower back areas). The facility substantiated neglect and terminated Employee E4, nurse aide. Continued review of the facility documentation revealed a written statement from Employee E4, nurse aide, dated February 10, 2025, which indicated, [Resident R1] fell off the bed when I gave (him/her) care, it was about 7:30 p.m. When I finished to clean one side of (his/her) body, then (he/she) tried to roll onto the other side (he/she) fell with the side rail of the bed. I immediately called the charge nurse and the supervisor to let them know about the incident. Continued review of facility's documentation revealed an interview statement, dated February 11, 2025, in which Employee E4, nurse aide, stated to the Director Nursing, I went to change [Resident R1], (he/she) can roll (himself/herself) over and grab side rail. I was changing (him/her) and asked (him/her) to roll to left side, (he/she) quickly rolled over, grabbed the siderail and (he/she) kept going, rolling off the bed onto the floor. Employee E4, nurse aide, continued, I do (him/her) myself cause (he/she) can roll over. Employee E4, nurse aide, confirmed to the Director of Nursing the employee did not have anyone with him while he was providing care to Resident R1. Review of Employee E4's personnel file revealed that Employee E4 was hired by the facility as a nurse aide on March 13, 2012. Review of the facility job description for nurse aides revealed, nurse aides assist residents with activities of daily living and implement care according to residents' care plans. Continued review of Employee E4's personnel file revealed the employee completed Safe Resident Handling training on July 25, 2024. Review of Resident R1's hospital records, dated February 18, 2025, revealed the resident was admitted to the hospital on February 10, 2025, after having a fall from bed. The hospital records indicated the resident sustained three injuries as a result of the fall: left humerus fracture, T11 wedge compression fracture and right shin contusion (type of hematoma - collection of blood under the skin). Continued review revealed the resident was not allowed to apply any weight to the left arm due to the humerus fracture and the resident had to remain on bedrest due to the T11 fracture. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident R1's wound consultant evaluation, dated February 19, 2025, revealed the resident was assessed for the wound on his right shin (contusion). The wound consultant noted the wound was a complicated hematoma that encompassed the lateral (side) calf. The hematoma had evidence of extravasation (leakage from blood vessels causing damage to the surrounding tissues) and visible eschar (dead tissue) with moderate oozing of sanguinous drainage (blood), moderate amount of induration (hardening of the skin) and fluctuance (fluid under the skin) with concern for expansion. The wound consultant recommended to send the resident to the hospital for urgent surgical and vascular evaluation out of concern for vascular compromise due to the size and expansion of the hematoma. The resident was subsequently transferred to the hospital and returned to the facility on [DATE]. Review of Resident R1's wound consultant evaluation, dated February 26, 2025, revealed the resident was assessed for the wound on (his/her) right shin. The wound consultant noted the hematoma continued with evidence of extravasation, eschar, oozing of sanguinous drainage, induration and fluctuance. The wound consultant recommended wound care consisting of Xeroform (non adherent dressing), absorbent pad, kling and ace wrap from toes to knees to provide compression and to monitor the area for vascular compromise. Interview conducted on March 3, 2025, at 9:32 a.m. with Resident R1 confirmed that (he/she) fell from bed while Employee E4, nurse aide, was providing care. Resident R1 also confirmed Employee E4, nurse aide, provided the care by alone and no other staff were present in the room to assist with care or repositioning. Resident R1 confirmed the injuries to (his/her) arm, back and shin were caused by the fall. Facility documentation and details of the incident were reviewed with the Director of Nursing on March 3, 2025, at 1:30 p.m. The Director of Nursing confirmed the facility substantiated the incident as neglect and terminated Employee E4, nurse aide. The facility failed to ensure that Resident R1 was free from neglect during provision of care, which resulted in actual harm to Resident R1 who fell out of bed, required transfer to the hospital and sustained fractures to the left humerus, and to vertebrate T11 of the spine and a contusion to the right shin. 28 Pa Code 201.18(b)(1) Management 28 Pa Code 211.10(d) Resident care policies 28 Pa Code 211.12(d)(5) Nursing services