

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Hopkins Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Review of the facility ' s policy titled Abuse Prohibition revised October 2022 defines abuse as the willful infliction of injury resulting in physical harm injury or mental anguish. The same policy states anyone who witnesses an incident . injuries of unknown origin will report the incident to his/her supervisor immediately . the supervisor will report the suspected abuse immediately to the Administrator. Review of Resident R1's clinical record revealed the resident diagnoses of chronic obstructive pulmonary disease (lung disease), vascular dementia (a type of dementia caused by damage to the blood vessels in the brain leading to cognitive decline) and documented as severely cognitively impaired. Review of facility documentation and investigation dated October 6, 2025, revealed Licensed Practical Nurse (LPN), Employee E3 noticed a bruise on Resident R1 ' s hand. Nurse Aide (NA), Employee E4 witness statement revealed the NA first noticed the bruising when providing care on the resident on Sunday, October 5, 2025. The same witness statement revealed the NA immediately informed the charge nurse assigned to Resident R1, who was LPN Employee E5. Surveyor's observation on October 9, 2025 at 2:00 p.m. of Resident R1's revealed a dark blue/purple discoloration on top of the resident's left hand. During an interview with NA, Employee E4 on October 9, 2025, at 3:51pm stated she knew Resident R1 well and was scheduled as the resident ' s aide from Saturday, October 4, 2025 through Monday, October 6, 2025. The NA stated on Saturday [DATE], during the 7-3 shift the NA did not notice any bruising. On October 5, 2025 on 7-3 shift while the NA was washing the resident she noted the bruise that was described as red with part purple discoloration to the resident ' s left hand. The NA said the resident was in pain and would not let the NA touch it. The NA stated in the interview and noted in the NA ' s witness statement that the NA stopped care and immediately told the nurse, LPN Employee E5. The nurse looked at Resident R1 ' s hand and said, ' Maybe it is poor circulation. Review of LPN, Employee E5 ' s witness statement dated October 7, 2025, stated he, Was made aware of discoloration to resident ' s left hand. right hand. Further review of Resident R1 ' s clinical record revealed no documented evidence that the LPN made the facility aware of this potential abuse allegation. During an interview with the Nursing Home Administrator and the Director of Nursing on October 9, 2025, at 4:00 p.m. confirmed LPN, E5 failed to report the injury of unknown origin when the bruise was initially found.28 Pa Code 211.12(d)(1) Nursing services</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: 395342	If continuation sheet Page 1 of 1