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	08/16/2024

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 46106 Based on a review of facility policies and procedures, employee personnel records, and staff interviews, it was determined that the facility failed to develop and implement an abuse prohibition policy that required a thorough investigation of prospective employees' employment history for one of five newly hired employees reviewed. (Employees 8) Findings include: The policy titled OPS300 Abuse Prohibition revision date October 24, 2022, states centers prohibit abuse, mistreatment, neglect, misappropriation of resident/ patient (hereinafter patient) property, and exploitation for all patients. The center will implement an abuse prohibition program through the following: screening of potential hires. A review of the Licensed Practical Nurse (LPN), Employee E8's personnel file revealed that Employee E8 was hired on May 22, 2024, out of state. A continued review of the personnel file revealed no documented evidence that an FBI or fingerprint was completed. Interview conducted on August 15, 2024, at 10:07 a.m. with Administrator, Employee E1 confirmed that Licensed Practical Nurse (LPN), Employee E8's didn't have FBI fingerprint done upon hire. 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 201.19 Personnel policies and procedures

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

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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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46993

Based on review of documentation, review of clinical records, and interview with staff, it was determined that the facility did not complete a thorough investigation of the alleged violation for one of 21 residents reviewed (Resident R252)

Findings include:

Review of R252's clinical record revealed he was admitted on [DATE] with medical diagnosis of dementia, visual loss in both eyes, difficulty walking, anxiety, tremors, muscle weakness, and type two diabetes.

Further review of clinical record revealed on July 23, 2024 at 4:24 PM, resident was seen sitting back in chair after attempting to elope down fire steps. Staff called to resident location and observed a small laceration above left eye and noted swelling to peri orbital area. Nurse practitioner, employee E10 , called and gave instructions to send resident out to emergency room for evaluation of unwitnessed fall and agitation. Progress note completed by licensed nurse, employee E12.

Progress note dated July 23, 2024 at 11:13 PM, indicated R252 was admitted to hospital under observation for injury to the head.

Review of facility provided investigation report, dated July 24, 2024, revealed that at approximately 3:40 PM, maintenance assistant - employee E14, went towards exit door on the 2nd floor long hall, entered the codes, and was headed towards the stairs when he noticed a resident following him and attempting to exit through the door. Staff stopped and tried to assist and re-direct the resident from exiting. In the midst, R252 became combative, hitting the staff member on his lips and forehead. Resident was re-directed back to second floor. Staff member indicated that he observed the resident pushing the door with his head while the door was closing, and it appeared to have made contact with the resident's forehead. Door was checked and was deemed to be operating correctly. Staff will be educated to look around the area prior to opening exit doors for any residents who may be near the door. Resident was assessed by nursing, and had a laceration to his forehead, above the left eye. Resident was sent out to the hospital for further evaluation. Following NP reviewing emergency room notes, the ER record stated that the resident said that he was hit by a staff member. An investigation was started immediately. Staff member and witnesses were interviewed, and statements obtained regarding the incident. Employee E14 was suspended pending investigation. Police Department was informed, and a police report submitted.

Further review of investigation report revealed a witness statement from maintenance assistant, employee E14 and housekeeping employee E15.

(continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Investigation report provided a statement from another resident R24, stating that she was sitting outside of her room in the hallway, as E14 was coming out of residents room, and heading down to the stairwell. As the door was slowly closing, R252 pushed the door open with his head, and unprovoked came behind E14 and started hitting him. R252 continued to hit E14. R24 stated that she heard E14 say what are you doing man and asked the resident to stop. R24 states after that point she was not able to witness anything after door closed. Shortly after, E15 guided R252 back to floor, while R24 alerted nursing staff of the incident. R24 stated that she was unable to recall the nurses that she alerted in the hallway. Interview with unit manager, E12 on August 16, 2024 at 12:15 PM, revealed that R252 was admitted to hospital with seizure due to rickettsiae and that he has no prior history of combative history. (Rickettsiae enter via the skin and spread through the bloodstream to infect vascular endothelium in the skin, brain, lungs, heart, kidneys, liver, gastrointestinal tract, and other organs) Further review of investigation report revealed 'Mandatory Abuse Report' form completed stating E14 as perpetrator. No evidence of statements or interviews conducted with nursing staff assigned to care for R252 during shift of incident. R252 remained hospitalized and discharged from facility on August 7, 2024. Findings discussed with facility administrator and director of nursing. Facility did not report the results of all investigations in accordance with State law, including to the State Survey Agency, within 5 working days of the incident; facility unable to provide PB-22 upon request. 28 Pa Code 201.18(b)(1) Management

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46106 Based on review of clinical records, interview with staff and review of facility policy, it was determined that the facility failed to revise a resident's PASARR (Pre-Admission Screening and Resident Review) with mental health diagnosis for 3 of 21 resident records reviewed (Resident R37, R63 and R15). Findings include: Review of facility policy titled Pre-Admission Screening for Mental Disorder and or Intellectual Disability Patients, revised February 16, 2024, revealed the center social worker or designated staff will assure that all patients with mental disorders and or intellectual disability receive appropriate pre-admission screening according to federal and state regulation. The social service will coordinate updates as needed and notify the state mental health authority after any significant change in the mental or physical changes in a resident who has a mental disorder. Review of resident R15's Quarterly Minimum Data Set (MDS- a federal mandated process for clinical assessment of all residents) dated August 2, 2024, revealed that Resident R15 was admitted into the facility on [DATE] and possesses mental health diagnosis of paranoid schizophrenia(a mental disorder characterized by hallucinations, delusions, disorganized thinking and behavior and paranoia),Parkinson (a brain disorder that causes unintended or uncontrollable movements), Bipolar disorder (a mental illness that causes unusual shifts in mood) and Depression (a mood disorder that causes persistent feeling of sadness). Review of resident PASARR level 1 screen completed on July 23, 2019, revealed the facility failed to indicate the resident's mental health diagnoses. Section 111A related questions related to a resident's diagnosis indicated that the resident has a serious mental illness diagnosis that included Bipolar. The mental health diagnoses was undated and failed to include resident R15 's mental health diagnosis of schizophrenia, depression, and Parkinson disease. Review of the clinical record on August 12, 2024, for Resident R37 revealed diagnoses that included schizoaffective disorder (schizoaffective -a mental disorder condition mix schizophrenia symptoms by delusions, hallucinations and mood disorder); depressive type (depression-a mood disorder that causes a persistent feeling of sadness and loss of interest). Review of Resident R37's PASARR Level I screen completed on July 15, 2023, failed to indicate the resident's mental health diagnosis. Section III- (Mental Health) indicated serious mental illness diagnoses that include Schizophrenia, Anxiety Disorder, Bipolar disorder Depressive Disorder may lead to chronic disability. Section III-A (related questions related to the resident's diagnoses) answered No that the resident does not have a mental health condition or suspect mental health condition that may lead to a chronic disability. Review resident's new diagnoses schizoaffective disorder, depressive that was add on March 27, 2023, facility failed to update resident's R37 PASSARR with a newly diagnosed mental disorder and do a significant change in status assessment. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record on August 13, 2024, for Resident R63 revealed diagnoses major depressive disorder (depression-a mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety disorder (anxiety-intense, excessive and persistent worry and fear about everyday situations) and psychotic (psychotic -a mental disorder form of thinking, hallucinations means seeing). Review of Resident R63's PASARR Level I screen completed on September 20, 2021, failed to indicate the resident's mental health diagnosis. Section III- (Mental Health) indicated serious mental illness diagnoses that include Schizophrenia, Anxiety Disorder, Bipolar disorder Depressive Disorder may lead to chronic disability. Section III-A (related questions related to the resident's diagnoses) answered No that the resident does not have a mental health condition or suspect mental health condition that may lead to a chronic disability. Review resident's new diagnoses schizoaffective disorder, depressive that was add on October 1, 2021, facility failed to update resident's R37 PASSARR with a newly diagnosed mental disorder and do a significant change in status assessment. Interview with Social Worker, Employee E17 on August 14, 2024, at 9:55. m. confirmed that resident's PASSARR was not update with the new diagnoses. 28 Pa. Code 211.5(f)(iv)(vi) Medical records 28 Pa. Code 211.10 (e) Resident Care Policies

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46993 Based on review of facility policy, clinical record review and interviews with staff, it was determined that the facility failed to ensure a Level 2 PASARR was conducted for residents with mental disorders as required for two of four residents reviewed. (Resident R86 and R13) Findings include: Review of facility policy 'pre-admission screening for mental disorder and/or intellectual disability patients,' revised on February 16, 2024, states the following: To ensure that all individuals are screened for a mental disorder (MD) and/or intellectual disability (ID) prior to admission, and To ensure that individuals identified with MD or ID are evaluated and receive care and services in the most integrated setting appropriate to their needs. Further review of facility policy revealed that social services will review PASRR to determine appropriate care needs and refer to the appropriate state designated authority when a patient is identified as having an evident or possible MD, ID or related condition. The PASRR(pre-admission screening for resident review) was created in 1987 through language in the Omnibus Budget Reconciliation Act(OBRA) and it has three goals: to identify individuals with mental illness and/or intellectual disability, to ensure that they are placed appropriately, whether in a nursing facility or the community , and to ensure they receive the services they require for their mental illness or intellectual disability. The PASARR Level 1 must be completed on all persons who are considering admission to a Medicaid certified nursing facility. A level 11 PASARR evaluation must be completed if the level 1 PASARR determined that the person is a targeted person with a mental illness or an intellectual disability. The level 11 PASARR would be determined if the placement or continued stay in the requested or current nursing facility is appropriate. Review of R86's minimum data set (MDS) completed on June 25, 2024, revealed that resident was admitted on [DATE] and readmitted on [DATE]. Review of R86's clinical record revealed medical history of psychosis, anxiety disorder, major depressive disorder, schizoaffective disorder, mood disorder, unspecified disorder of adult personality and behavior. Further review of clinical record revealed that Level 1 PASRR form was completed on December 12, 2023 Review of R86's Level 1 PASRR revealed that resident met criteria to have further PASRR Level 2 evaluation. Continued review of the clinical record revealed that there was no indication in the record that a level 2 PASARR evaluation had been completed. Facility unable to provide R86's Level 2 PASRR form upon request. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of residents R13 Quarterly Minimum Data Set (MDS- a federal mandated process for clinical assessment of all residents) dated August 2, 2024, revealed that resident R 13 was admitted into the facility on [DATE]. This resident has diagnoses including anxiety (a mental condition characterized by excessive apprehensiveness about perceived thoughts), depression (a mood disorder that causes persistent feeling of sadness), schizophrenia a mental disorder characterized by hallucinations, delusions, disorganized thinking and behavior),and paranoia), dementia(general term for loss of memory, language, problem solving and other thinking abilities) and Alzheimer's disease(a type of dementia/ a brain disease that causes a slow decline in memory, thinking and reasoning skills). Review of resident R13's care plan dated January 10, 2017, revealed Resident meets PASRR ll level of Determination secondary to diagnosis of serious mental illness. Review of resident R13's PASRR level 1 dated October 17, 2013, and revised September 1, 2028, revealed the facility failed to indicate the resident's mental health diagnoses. Section 111A related questions related to a resident's diagnosis indicated that the resident has NO mental health conditions or suspected mental health condition other than dementia. Further review of resident R 13's PASRR revealed at section V111 PASRR level 1 screening outcome was determined that this resident has a negative screen for serious mental illness, intellectual disability and no further evaluation is necessary. Continued review of resident's clinical record revealed that there was no indication in the record that a level ll PaSARR evaluation had been completed. Interview on August 14, 2024, at 09:30 a.m. with director of social services Employee E 17 confirmed that Resident R 13's PASRR level 1 was incomplete, and this resident required and PASARR level 11 evaluation that was not completed to his knowledge. Employee E 17 confirmed that there was no documentation available for review at the time of survey that a level 11 PASARR evaluation was completed for resident R13. 28 Pa Code 201.14(a)Responsibility of licensee

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277 Based on observations, review of facility policy, review of clinical records, and interview with resident and staff it was determined that the facility failed to develop and implement comprehensive, person-centered care plans to address resident care needs related to restorative nursing program, antipsychotic use, and refusal of care for three of 21 residents reviewed (Resident R92, R89, and R70). Findings Include: Review of facility policy 'Person Centered Care Plan,' revised October 24, 2022, indicates that A comprehensive person-centered care plan must be developed for each patient and must describe the following: any services that would otherwise be required but are not provided due to the patient's exercise of rights, including the right to refuse treatment . Review of Resident R92's admission Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated June 3, 2024, revealed the resident had moderate cognitive impairment and diagnoses of dementia (symptoms affecting memory, thinking and social abilities) and adjustment disorder with mixed anxiety (feeling of worry, nervousness, or unease) and depressed mood. Continued review of Resident R92's admission MDS dated [DATE], revealed the resident received antipsychotic medications (treats psychosis symptoms such as delusions, hallucinations, and paranoia) on a routine basis. Review of Resident R92's physician order summary revealed physician orders dated May 30, 2024, for Quetiapine Fumarate (also known as Seroquel - antipsychotic medication that helps to regulate mood, behavior, and thoughts) 25 milligrams (mg) one time a day for agitation and Quetiapine Fumarate 50mg one time a day for dementia. Review of Resident R92's clinical record revealed no documented evidence a comprehensive care plan was developed and implemented related to the resident's diagnosis of dementia and use of antipsychotic medication. Review of Resident R89's quarterly MDS dated [DATE], revealed the resident had moderate cognitive impairment and had diagnoses of stroke (when part of the brain does not have enough blood flow), and hemiplegia (paralysis of one side of the body) or hemiparesis (muscle weakness on one side of the body). Further review of Resident R89's quarterly MDS dated [DATE], revealed the resident had impairment in range of motion to the upper extremity on one side. Observations on August 12, 2024, at 10:37 a.m. revealed Resident R89 had limited range of motion to the left upper extremity. Resident R89 reported impairment to the left upper extremity was the result of a stroke. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R89's occupational discharge summary dated July 12, 2024, revealed a restorative range of motion program was recommended to prevent contractures (condition of shortening and hardening of muscles, tendons, or other tissue leading to deformity and rigidity of joints). Review of Resident R89's physical therapy discharge summary dated July 16, 2024, revealed a restorative nursing program for ambulation was recommended to prevent functional decline. Review of Resident R89's clinical record revealed no documented evidence a comprehensive care plan was developed and implemented related to the restorative nursing program as recommended by the therapy department. Review of R70's clinical record on August 14, 2024 at 2:22 PM, revealed medical history of hemiplegia (paralysis) of left non-dominant side, malignant (cancerous) neoplasm of cerebellum, pain in bilateral shoulders. During interview with R70 on August 12, 2024 at 10:00 AM, he stated that staff do not assist him out of bed and that there is not enough staff to assist him out of bed. Interview with unit manager, employee E12, on August 12, 2024 at 10:15 AM ,2nd floor unit, revealed that resident has history of refusing care, refusing medications. Review of R70's progress notes dated August 14, 2024 at 9:42 AM revealed resident refused Senna oral tablet 8.6 mg. Review of R70's progress notes dated August 13, 2024 at 10:19 AM revealed resident refused medication this morning. Education on importance in taking medication given. Several attempts, resident still refused. Review of R70's progress notes dated August 1, 2024 at 11:36 PM, revealed resident refused non-skid footwear for safety. Review of R70's progress notes dated August 1, 2024 at 8:38 PM revealed resident refused Atorvastatin Calcium tablet 80mg. Review of R70's progress notes dated July 27, 2024 at 12:51 PM, revealed resident refused vital signs, stating that he is alive so there is no need. Review of R70's progress notes dated July 27, 2024 at 10:19 AM revealed resident refused metoprolol succinate extended release 25mg. Review of R70's progress notes dated July 27, 2024 at 10:18 AM revealed resident refused Aspirin 81mg. Further review of R70's progress notes for July 2024 revealed refusal of medications Apixaban 5mg, refused all prescribed medicine with no explanation , gabapentin 100mg, and atorvastatin 80mg. Review of R70's care plan revealed no evidence of interventions related to refusal of care, or education regarding alternatives and consequences. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.10 (d) Resident care policies. 28 Pa. Code 211.12 (d)(3) Nursing services. 28 Pa. Code 211.12 (d)(5) Nursing services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 43277 Based on observations, review of facility policy, review of clinical records, and staff and resident interviews it was determined that the facility failed to implement resident-directed care and treatment consistent with the resident's comprehensive assessment and care plan, physician orders, and professional standards of practice for two of 21 residents reviewed (Resident R22 and R29). Findings Include: Review of facility policy 'Enhanced Patient Supervision: Continuous 1:1,' revised on September 1, 2022, indicates that the designated staff will only be involved with the delivery of care to this patient and no other ; the designated staff must be with the patient at all times; must obtain coverage for breaks; and will provide positive interaction in conjunction with therapeutic interventions. Review of Resident R22's comprehensive Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated May 23, 2024, revealed the resident was cognitively intact and had a diagnosis of dysphagia (difficulty swallowing). Review of Resident R22's clinical record revealed a physician order dated October 31, 2023, for 1:1 supervision with all meals. Review of Resident R22's comprehensive care plan revised November 6, 2023, revealed the resident was at risk for impaired swallowing and required 1:1 supervision with meals for aspiration precautions. Interview on August 12, 2024, at 12:50 p.m. Resident R22 denied supervision from staff during mealtimes. Resident R22 reported he consumes meals in his room. Interview on August 14, 2024, at 10:28 a.m. Licensed Nurse, Employee E18, reported Resident R22 does not have supervision for meals. Observations on August 14, 2024, at 12:02 p.m. revealed Resident R22 was eating lunch in his room without supervision. Interview on August 14, 2024, at 12:03 p.m. with Nurse Aide, Employee E19, confirmed Resident R22 did not have supervision with meals. Review of R29's clinical record revealed medical history of falling, major depressive disorder, post traumatic stress disorder, muscle weakness, dementia and agitation, unsteadiness on feet, contracture of right hand, traumatic brain injury. Review of R29's minimum data set (MDS) completed on November 29, 2023, section G - Functional Status, indicates that resident required one person physical assistance with bed mobility and transfer, and two or more person assist for toilet use. Review of residents care plan confirmed MDS evaluation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R29's physicians orders revealed an order placed on February 14, 2024 at 3:19 PM for 1:1 supervision at all time - every shift for aggressive behavior, placed by facility's nurse practitioner, employee E10. Review of facility provided investigation report revealed that on February 15, 2024 at approximately 10:00 AM, resident was observed to have left hip externally rotated, shortened, and swollen. R29 was transferred to emergency room for evaluation which resulted in left hip fracture and an operation was done on February 16, 2024. Review of 'After Visit Summary,' dated February 20, 2024 states Per the facility they found the patient in bed sleeping past the normal time he usually wakes up. He was in the process of getting some physical therapy when they noticed he was guarding his left hip. They examined the left hip when they grew suspicious that he had fractured the hip from a fall. Further review of investigation report revealed a statement by facility's nurse aide, employee E11, from February 15, 2024 states the following: I sat with him from 8 AM til juice came on floor He was in bed still sleeping so I left door open and started pouring drinks in hall until 9:30 . I did see him get up I didn't see him fall He did not complain of pain, I always have someone with me because he hit me. Findings confirmed with facility's director of nursing and administrator. 28 Pa Code 211.12(d)(5) Nursing services

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277 Based on observations, review of facility policy, review of clinical records, and staff and resident interviews it was determined that the facility failed to ensure a resident with limited range of motion received treatment and services to maintain or improve range of motion/mobility for one of one resident reviewed for limited range of motion (Resident R89). Findings Include: Review of facility policy Restorative Nursing revised August 7, 2023, revealed restorative programs are coordinated by nursing or in collaboration with rehabilitative and are patient specific based on individual patient needs. A licensed nurse must supervise the activities in a restorative nursing program. Review of Resident R89's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated May 8, 2024, revealed the resident had moderate cognitive impairment and had diagnoses of stroke (when part of the brain does not have enough blood flow), and hemiplegia (paralysis of one side of the body) or hemiparesis (muscle weakness on one side of the body). Further review of Resident R89's quarterly MDS dated [DATE], revealed the resident had impairment in range of motion to the upper extremity on one side. Observations on August 12, 2024, at 10:37 a.m. revealed Resident R89 had limited range of motion to the left upper extremity. Resident R89 reported impairment to the left upper extremity was the result of a stroke. Review of Resident R89's occupational discharge summary dated July 12, 2024, revealed a restorative range of motion program was recommended to prevent contractures (condition of shortening and hardening of muscles, tendons, or other tissue leading to deformity and rigidity of joints). Review of Resident R89's physical therapy discharge summary dated July 16, 2024, revealed a restorative nursing program for ambulation was recommended to prevent functional decline. Review of Rehab Restorative Transition Program documentation dated July 16, 2024, revealed a restorative nursing program was designed by physical and occupational therapy. The program indicated that nursing staff would ambulate Resident R89 75 feet with limited assistance using a rolling walker. Further review of the program revealed Resident R89 would tolerate active assist range of motion 3 sets of 15 reps each to left shoulder, left elbow, left wrist, and left hand. Further review of the Rehab Restorative Transition Program documentation dated July 16, 2024, revealed Physical Therapist, Employee E21, and Occupational Therapist, Employee E22, provided education for nursing staff pertaining to the restorative nursing programs recommended for Resident R89. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on August 15, 2024, at 11:50 a.m. with the Director of Rehabilitation, Employee E20, revealed when the therapy department recommends a restorative nursing program the nursing staff are expected to follow-through and implement the recommended program. Interview on August 15, 2024, at 12:49 p.m. Resident R89 denied being ambulated or having exercises completed with nursing staff. Interview on August 15, 2024, at 12:52 with Nurse Aide, Employee E19, and Nurse Aide, Employee E23, staff denied completing ambulation or active range of motion exercises. Review of Resident R89's clinical record revealed no documented evidence staff were documenting restorative range of motion program as being completed. 28 Pa. Code 211.12 (d)(3) Nursing services. 28 Pa. Code 211.12 (d)(5) Nursing services.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347 Based on a review of clinical records, review of facility policies, observations, resident, and staff interviews, it was determined that the facility failed to timely ensure the location of a resident who went on a leave of absence and failed to provide education on how to monitor blood sugar levels per sliding scale and administration of insulin medication. This failure resulted in an Immediate jeopardy situation for Resident R1 who was provided insulin medication without education of blood sugar management and insulin administration prior to a leave of absence and for the failure to ensure the location of Resident R1 who failed to return to the facility per physician's order for one of 31 residents reviewed. (Resident R1). Findings include: Review of facility policy titled Leave of Absence/Therapeutic Leave: Patient revised November 1, 2023, revealed the patient must have a physician's order for a leave of absence (LOA)/ Therapeutic leave Therapeutic leave is described as an absence for the purpose other than required hospitalization . The release of Responsibility for Leave of Absence/ Therapeutic leave form must be completed when the patient leaves and returns to the center. Further review of this policy states Prior to leaving the center, the staff will review patient care and medication needs with the patient/ and or the person accepting responsibility for the patient. Review of the facility abuse policy titled Abuse Prohibition revised on October 24, 2024, revealed the term neglect is defined as the failure indifference, or disregard of the center, its employees, or service providers to provide care, comfort, safety, goods and service to a patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. This includes the failure to implement an effective communication system across all shifts for communicating necessary care and information between the center, patient, practitioners, and patient representatives. Review of insulin manufacturer summary for safety of insulin (brand name Humalog, non-brand name insulin Lispro) revealed that possible side effects of omitted medication could possibly lead to low blood sugar (hypoglycemia), low potassium in your blood (hypokalemia), heart failure, sudden onset of high blood sugar (hyperglycemia) and high amounts of ketones in the blood or urine (ketoacidosis) due to insulin pump, all possible fatal consequences. Review of Resident R81's clinical record revealed that Resident R81 was admitted to the facility June 16, 2023, secondary to deficits in mobility and ADLs (activities of daily living). Review of Resident R81's clinical record revealed that the resident was admited to the facility on [DATE], from the hospital. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of hospital documentation revealed Patient reported feeling dizzy and fell and was unable to get herself up. In the emergency room , blood sugar was found to be over 1000 (normal levels between 70-100) and sodium level of 113 (normal level 135). She was given IV (intravenous) fluids. CT (computed tomography) of her head showed chronic lacunar infarcts (stroke). Patient's mental status became altered and stopped responding leading her to the facility for skilled nursing. Review of Resident R81's quarterly Minimum Data Set (resident's care needs assessment) dated May 24, 2024, revealed that Resident R81 had diagnoses of asthma (lung disorder characterized by narrowing of the airways), depression (major loss of interest in pleasurable activities), schizophrenia (mental disease characterized by loss of reality), seizure disorder (neurological disorder that cause brief episodes of unresponsiveness), hypertension (high blood pressure), renal failure, diabetes (failure of the body to produce insulin), and hyponatremia (low blood sodium levels). Continued review of Resident R81's quarterly MDS revealed that the resident had impairment on one side of the body and required assisted devices of a walker and wheelchair. Further review of this assessment revealed that Resident R81 had a BIMS (brief interview of mental status) score of 12 which indicated that the resident had moderate cognitive impairment. Review of Resident R81's current care plan revealed focus areas which included Resident/patient exhibits or has the potential to exhibit physical behaviors related to ineffective coping skills, i.e., poor anger management, poor impulse control. Resident R81 has diagnosis of psychiatric disorder depression and anxiety and is at risk for complications related to the use of psychotropic drugs Trazadone and Quetiapine. The resident has a diagnosis of diabetes and is insulin dependent. Access and record blood glucose levels before meals and administer hypoglycemic medications as ordered. Resident R81 is at risk for falls due to impaired mobility and history of falls. Resident exhibits or is at risk for respiratory complications related to tracheostomy, and a history of sleep apnea. Review of physician order by Nurse practitioner, Employee E10, dated June 3, 2023, revealed that Resident R81 was approved for leave of absence with family from June 8, 2024, at 8:30 a.m. until June 9, 2024, at 6:00 p.m. with medications. Review of Resident R81's nursing notes dated June 10, 2024, revealed that Resident R81 left the faciity on [DATE], and did not return on the anticipated ordered time of June 9, 2024, at 6:00 p.m. Continued review of Resident R81's nursing note dated June 10, 2024, written by Licensed nurse Employee E5 revealed Resident did not return from the LOA (leave of absence) at the time frame ordered. Call placed to listed number on information sheet for this resident and the voice mail said, this person is not accepting calls at this time. Call placed to guardian who did not have a mailbox set up at this time. Called residents sister, who I left a message for, re (reference) above and steps of calling the police for a wellness check. Sister called back states she did not know she went out on an LOA and she will try to get in touch with her. I asked if she had a different number than what I had, and she gave it to me. I called that number and left a message re above. [Resident R81] called back stating, I am on my way back, my sister just called and said that you were calling the police. I conformed the plan of care that was discussed with [resident sister] to which the resident replied that you gave me two bottles of meds so I thought that I could stay out for 2 days I explained to the resident that I ordered the meds that she would need for the time that she had requested her LOA. The resident replied, I am on my way back now my driver is coming now. DON notified of above and phone number updated. (continued on next page)

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

There was no documented evidence that the facility attempted to locate the resident prior to June 10, 2024 during the 7-3 shift. The facility was unaware of Resident R81's whereabouts.

Continued review of nursing notes revealed that after Resident R81 returned she stated I took no meds but monitored my sugar, and took my insulin. I asked if she had a log of her blood sugars, she said no. Resident was educated on need to take meds as prescribed and to return to facility a time requested from her LOA. Resident was also shown the LOA med form with the time and dates that she the resident requested. The resident replied that she did not know that that paper was in there and that she was confused when she seen the order date of 6/3/24. DON and family advised of residents return.

Interview with Nurse Practitioner, Employee E10 confirmed that she authorized Resident R81 leave of absence for the time of June 8, 2024, at 8:30 a.m. to June 9, 2024, at 6:00 p.m.

Review of medication order for Resident R81's leave of absence revealed that Licensed nurse, Employee E5 sent a request to the pharmacy for the following medication for Resident R81 to take with her on her LOA. The detailed list of medication included:

Metformin 500 mg (milligrams), ordered to take 2 tablets twice a day. (diabetic medication used to lower blood sugar levels) resident given 6 tablets.

Quetiapine 100 mg ordered 1 tab at bedtime (antipsychotic used to treat schizophrenia) resident given 1 tablet.

Quetiapine 50 mg ordered to take one tablet twice a day (antipsychotic used to treat schizophrenia) resident given 2 tablets.

Trazadone 50 mg ordered to take 1/2 tab / 0.5 tab at bedtime for anxiety daily (antidepressive)

Insulin glargine 100 ml ordered admin 4o units sub q at bedtime, (hormone) resident given 40 units.

Insulin lispro 100iu inject 6 units inject subcutaneous (just under the skin) at bedtime 1 pen, resident given 1 pen.

Insulin lispro 100 iu inject 20 units inject subcutaneous (just under the skin) before meals / hold if not eating resident given 1 pen.

Aspirin 81 mg ordered to take 1 tab daily at 9am, resident given 1 tablet to prevent a stroke.

Atorvastatin calcium 40 mg (cholesterol medication) ordered for 1 tab daily at 9 am resident given one tablet.

Ferrous sulfate 300 mg ordered 1 tab daily at 10 a.m. (iron) resident given 1 tablet.

Gabapentin 800 mg ordered (anticonvulsant) 1 tab by mouth three times a day, 6 a.m., 2 p.m., 10 p.m., resident given 4 tablets.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Guaifenesin liquid 100mg/15 ml order to take 10 ml at 9 am and 9 pm (cough suppressant) resident given 20 ml. Lacosamide 150 mg ordered one tab every 12 hours (seizures medication), resident given 2 tablets. Interview with Licensed nurse, Employe E5 on August 13, 11:25 a.m. revealed the protocol of a resident's leave of absence was the resident has to request the leave to her (unit manager) a few days prior, (enough time to order medications for the leave) then she will get approval and order from the physician for the leave of absence. Upon returning the resident is required to provide the bag of medication to examine. The residents should then receive an accu check (blood sugar check) and skin check when arriving back to the facility. Licensed nurse, Employee E5 stated that Resident R81 came to her and requested the leave from June 8th through June 9th . Employee E5 then got physician orders for the leave and ordered medication based on the number of hours the resident would be out. Licensed nurse, Employee E5 stated that she was not on duty on June 8, 2024, when the resident left for LOA. When she arrived on the floor on Monday August 10, 2024, at 7:00 a.m. she became aware the Resident R81 has not yet returned. She immediately tried to call the resident and called resident's family to locate her. Licensed nurse, Employee 5 confirmed that she was concerned of the resident's need for crucial medications. When Resident R81 returned Licensed nurse, Employee, E5 requested accu check log, and it was noted that the resident failed to record her blood sugar levels. Interview with Resident R81 on August 13, 2024, at 11: 55 a.m. confirmed that she left for the weekend and everyone went crazy the DON threatened to call the police if she did not come back. Resident R81 stated that she told someone she was not coming back till after the weekend. Resident R81 stated that she went to Licensed nurse, Employee E5 and requested the leave and few days prior to leaving. The morning of June 8, 2024, Resident R81 stated she was in a hurry my ride is downstairs waiting and Licensed nurse, Employee E6 handed her a bag of meds with needles. Resident R81 stated she was not educated or told what to do with the medications. Interview with Director of Nursing, Employee E2 on August 13, 2024, at 1:25 p.m. revealed that the resident had told a nurse that she was going to extend her loa until Monday. Director of Nursing Employee E2 provided a nursing note that stated Resident R81 will be returning on Monday, June 10, 2024. Review of nursing note written by Licensed nurse, Employee E9 on June 8, 2024, at 5:41 p.m. indicated that Resident on LOA w/ friend and will return Monday 6/10/24 resident has all medication with her. Interview with Licensed nurse, Employee E9 on August 15, 2024, at 9:05 a.m. revealed that she was on duty the morning of June 8, 2024, as unit manager and she state that Resident R81 left the facility, she did not remember if anyone was with her, and said she would be coming back on Monday (June 10, 2024). Employee E9 wrote a note in the chart. There was no documented evidence that Licensed nurse, Employee E9 notify the physician or obtain a new order for extended LOA and additional medications required for Resident R81. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Licensed nurse, Employee E6 on August 14, 2024, at 4:45 p.m. revealed that she provided the resident with the bag of medications for her to leave with. Licensed nurse, Employee E6 stated that bag was stapled shut, she stated that she eye bawled the medication to confirm the contents. Employee E6 was not able to confirm if she educated the resident at the time of departure or sometime previously. Licensed nurse, Employee E6 stated that she knew what to do with the medications. Licensed nurse, Employee E6 denied suppling the resident with supplies needed such as accu check glucose meter, lancets, and test strips, stating that Resident R81 told her she had all supplies needed. There was no evidence that the facility initiated efforts to locate the resident for 2 shifts after the resident failed to return to the facility on [DATE]. It was not until the 7-3 shifts on June 10, 2024, that the resident was able to be located. There was no additional physician order obtain for the resident stay out of the facility passed June 9, 2024. An Immediate Jeopardy situation was identified to the Nursing Home Administrator on August 15, 2024, at 11:34 a.m. for the facility's failure to ensure that Resident R81 was provided education of how to monitor blood sugar level per sliding scale prior to leave of absence from the facility and how to administer insulin medication. The facility failed to timely ensure the safety and location of Resident R81 who was on a leave of absence. The following action plan was received and accepted on August 15, 2024, at 2:34 p.m. 1.Resident educated on how to assess, monitor, and administer blood sugar levels per sliding scale. 2. Thirty days look back completed on resident with active LOA orders that receive insulin to ensure insulin education has been provided. 3. DON (Director of Nursing) or designee to re-educated Licensed nursing staff on insulin education prior to the resident leaving for an ordered LOA. Licensed nursing staff will also be re-educated on LOA policy and when to initiate effort/ notification to locate a resident who does not return to the facility. 4. Weekly audits x 12 to be completed for all resident who went on a LOA that receive insulin to ensure education was provided prior to LOA occurring. Results of audits to be reviewed at QAPI meeting. Interview with all licensed staff confirm that they were in-service on Interview with Resident R81 confirmed that the resident received education on monitoring blood sugar levels per sliding scale. Interview with licensed nursing staff reported that they received inservice on the LOA policy. Review of facility thirty day look back of leaves of absence confirmed that education was completed on insulin administration. The Immediate Jeopardy was lifted on August 16, 2024, at 2:02 p.m. 2024. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.20 (a)(1)(b) Staff development (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	28 Pa. Code 211.12 (d)(5) Nursing Services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 43277 Based on review of clinical records it was determined that the facility failed to provide pharmaceutical services to assure the acquiring and administering of medications to meet the needs of each resident for one of 21 residents reviewed (Resident R95). Findings Include: Review of Resident R95's admission Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated July 23, 2024, revealed the resident had severe cognitive impairment and a diagnosis of benign prostatic hyperplasia (a condition in which the flow of urine is blocked due to the enlargement of the prostate gland). Review of Resident R95's August 2024 medication administration record revealed a physician order with a start date of August 9, 2024, for Cephalexin (antibiotic that fights bacteria in your body) 500 milligrams (mg) four times a day (scheduled at 6:00 a.m., 11:00 a.m., 4:00 p.m., and 9:00 p.m.) for urinary tract infection. Per a review of the medication administration record, the Cephalexin was not signed out as administered for the 4:00 p.m. and 9:00 p.m. doses on August 9, 2024. Review of Resident R95's clinical record revealed an order administration note for the Cephalexin 500mg dated August 9, 2024, at 7:03 p.m. medication not available. Continued review of Resident R95's clinical record revealed an order administration note for the Cephalexin 500mg dated August 9, 2024, at 7:51 p.m. awaiting pharm [pharmacy] Further review of Resident R95's clinical record revealed no documented evidence that the physician was made aware of the missed doses, that an alternate treatment was requested, or specific orders for monitoring while the medication was unavailable. Review of the clinical record revealed no documented evidence the licensed nurse determined the reason for unavailability, length of time medication is unavailable, and what efforts were attempted to obtain the medication. 28 Pa. Code 211.9 (a)(1) Pharmacy Services. 28 Pa. Code 211.9 (d) Pharmacy Services. 28 Pa. Code 211.12 (d)(1) Nursing Services.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347 Based on observation, review of facility documentation and interviews with staff, it was determined that the Nursing Home Administrator and Director of Nursing failed to effectively manage the facility resulting in an immediate jeopardy situation regarding the safety of a resident who was on a leave of absence relating to the failure to located resident after not returning and not properly educating the resident on medication administration prior to leave of absence For one resident (Resident R 81) . Findings include: Review of the job description of the Nursing Home Administrator (NHA) revealed that, the primary responsibility is accountable for all activities and departments of the Center subject to rules and regulations promulgated by government agencies to ensure proper health care services to residents. The Administrator administers, directs, and coordinates all activities of the Center to assure that the highest degree of quality of care is consistently provided to residents. The job description of the Director of Nursing (DON) revealed that, This position has overall accountability for providing leadership, direction, and administration of day-to-day operations associated with direct patient care activities, nursing practice, and clinical education and Collaborates and coordinates with other departments and professionals to provide timely, safe and effective care consistent with individuals' needs, choices and preferences; .Organizes and leads effective clinical meetings, rounds, shift to shift communication and huddles to assure effective patient/resident outcomes. The DON responsibility also includes to ensure that Physician Orders are followed as prescribed. Review of facility policy titled Leave of Absence/Therapeutic Leave: Patient revised November 1, 2023, revealed the patient must have a physician's order for a leave of absence (LOA)/ Therapeutic leave Therapeutic leave is described as an absence for the purpose other than required hospitalization . The release of Responsibility for Leave of Absence/ Therapeutic leave form must be completed when the patient leaves and returns to the center. Further review of this policy states Prior to leaving the center, the staff will review patient care and medication needs with the patient/ and or the person accepting responsibility for the patient. Review of resident R 81 Quarterly Minimum Data Set (a federal mandated process for clinical assessments for resident in a long-term care facility) dated May 24, 2024, revealed that resident R 81 has diagnoses of asthma, depression, schizophrenia, seizure disorder, hypertension, renal failure, diabetes, and hyponatremia. Resident R81's function ability indicated that resident R 81 was impaired one side and required assisted devices of a walker and wheelchair. Further review of this assessment revealed that resident 81 had a BIMS (brief mental status) score of 12. The score ranges from 0-15, 12 indicating moderate cognitive impairment. Resident 81's listed urgent medications included insulin, antiseizure, antipsychotics, antianxiety, opioids, antiplatelet and hypoglycemic medications. The resident has no discharge plan in place. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident 81's care plan (a document that summarizes a person's health conditions, treatments and care needs) identified residents R 81 care needs exhibits or has the potential to exhibit physical behaviors. Related to: Ineffective coping skills, i.e., poor anger management, poor impulse control. Resident R 81 has diagnosis of Psychiatric Disorder depression and anxiety and is at risk for complications related to the use of psychotropic drugs trazadone and Quetiapine. The resident has a diagnosis of diabetes: Insulin Dependent and required to Access and record blood glucose levels before meals. And administer hypoglycemic medications as ordered. Resident 81 is at risk for falls: Impaired mobility due to a history of falls. Resident exhibits or is at risk for respiratory complications related to tracheostomy, and a history of sleep apnea. Review of resident 81's clinical record nursing notes dated June 10, 2024, revealed that resident R81 left the faciity on [DATE] and did not return on the anticipated ordered time of June 9, 2024, at 06:00 p.m. Resident R 81 unknown whereabouts and with insufficient amount of vital medications. Review of resident 81's clinical record nursing note dated June 10, 2024; Written by Licensed nurse Employee E 5 revealed Resident did not return from the LOA at the time frame ordered. Call placed to listed number on information sheet for this resident and the voice mail said, this person is not accepting calls at this time. Call placed to guardian who did not have a mailbox set up at this time. Called residents sister, who I left a message for, re above and steps of calling the police for a wellness check. Sister called back states she did not know she went out on an LOA, and she will try to get in touch with her. I asked if she had a different number than what I had, and she gave me. I called that number and left a message re above. [NAME] called back stating, I am on my way back, my sister just called and said that you were calling the police. I conformed the plan of care that was discussed with [NAME] to which the resident replied that you gave me two bottles of meds so I thought that I could stay out for 2 days I explained to the resident that I ordered the meds that she would need for the time that she had requested her LOA. The resident replied, I am on my way back now my driver is coming now. DON notified of above and phone number updated. , After resident R 81 returned she stated I took no meds but monitored my sugar, and took my insulin. I asked if she had a log of her blood sugars, she said no. Resident was educated on need to take meds as prescribed and to return to facility a time requested from her LOA. Resident was also shown the LOA med form with the time and dates that she the resident requested The resident replied that she did not know that that paper was in there and that she was confused when she seen the order date of 6/3/24. DON and family advised of residents return. Review of physician order (written by nurse practitioner employee E10), dated June 3, 2023, revealed that resident R 81 was approved for leave of absence with family from the date of June 8, 2024, at 8:30 a.m. until return June 9, 2024, at 06:00 p.m. with medications. (continued on next page)

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 08/16/2024
NAME OF PROVIDER OR SUPPLIER: Hopkins Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 8100 Washington Lane, Wyncote, PA 19095	

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility failed to locate resident when the resident did not return at appointed time and or notify physician when she decided to extend her loa causes a lapse or insufficient amount of critical medications. There is an evident lack of communication causing possible harm to residents regarding leave of the facility and unsupervised medication administration. The facility failed to ensure that a resident a resident was provided education of how to assess monitor and administer blood sugar level per sliding scale prior to leave of absence from the facility. The facility failed to timely ensure the safety of a resident who was on a leave of absence. An Immediate Jeopardy situation was identified to the Nursing Home Administrator and the director of nursing on August 15, 2024, at 11:34 a.m. for the facility's failure to ensure resident's safety was preserved while on Leave of absence relating to Resident 81, with diagnosis of diabetes mellitus, who is insulin dependent requested a leave of absence for 24 hours. Physician order was obtained for 24 hours leave of absence. Resident was given insulin syringes to self-self-administered insulin and medications without prior education in how to test, assess and monitor blood sugar levels per sliding scale. And the facility obtained a physician's order for the resident to go on a leave of absence with family from June 8, 2024, at 8:30 a.m. and return on June 9, 2024, at 6:30 p.m. The facility did not contact and initiate efforts to locate the resident for 2 shifts after the resident failed to return to the facility. It was not until the 7-3 shifts on June 10, 2024 that the resident was able to be located. There was no additional physician order obtain for the resident stay out of the facility passed June 9, 2024. 28 Pa Code 201.14 (a) Responsibility of licensee 28 Pa Code 201.18(a) Management

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 48347 Based on Review of facility documentation, clinical record review and interviews with staff, it was determined that the facility failed to maintain an effective antibiotic stewardship program that included a system to effectively monitor antibiotic usage for seven of seven months reviewed. Finding include: A review of the CDC (Center for Disease Control and Prevention) guideline, The core element of Antibiotic Stewardship for Nursing Homes, revealed that improving the use of antibiotic resistance is a national priority. 1. Antibiotic Stewardship refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. 2 the Center for Disease Control and Prevention (CDC) recommends that all acute care hospitals implement an antibiotic stewardship program (ASP) and outlined the seven core elements which are necessary for implementing successful ASP's. 2.CDC also recommends that all nursing home take steps to improve antibiotic prescribing practices and reduce inappropriate use. Nursing Homes monitor both antibiotic use and practices and outcomes related to antibiotic use to guide practice changes and track impact of the new interventions. Data on adherence to antibiotic prescribing policies and antibiotic use are shared with clinicians and nurses to maintain awareness about the progress being made in antibiotic stewardship. Clinician response to antibiotic use feedback (e.g. acceptance) may help determine whether feedback is effective in changing prescribing behaviors. Integrate the dispensing and consultant pharmacist into the clinical care team as key partners in supporting antibiotic stewardship in nursing homes. Pharmacist can provide assistance in ensuring antibiotics are ordered appropriately, reviewing culture data, and developing antibiotic monitoring and infection management guidance in collaboration with nursing and clinical leaders. Identify clinical situations which may be driving inappropriately courses of antibiotics such as asymptomatic bacteriuria or urinary tract infection prophylaxis and implement specific interventions to improve use. Perform reviews on resident medical records for new antibiotic starts to determine whether the clinical assessment, prescription documentation and antibiotic selection were in accordance with facility antibiotic use policies and practices. When conducted over time, monitoring process measures can assess whether antibiotic prescribing policies are being followed by staff and clinicians. Trach the amount of antibiotic used in your nursing home to review patterns of use and determine the impact of new stewardship interventions. Some antibiotic use measures (e.g. prevalence surveys) provide a snapshot of information; while others like nursing home-initiated antibiotic starts and days of therapy are calculated and tracked on an ongoing basis. Selecting which antibiotic use measure and track should be based on the type of practice interventions being implemented. Interventions designed to shorten the duration of an antibiotic courses, or discontinue antibiotics based on post prescription review, may not necessarily change the rate of antibiotic state but would decrease the antibiotic. (continued on next page)

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

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility documentation of monthly antibiotic/ infection analysis revealed that the record for each month has insufficient and missing information. The reports did not include any surveillance or tracking information. The monthly reports including the resident names, date, antibiotic, date started and precaution. The documents did not records length of antibiotic, any labs, site of infection, symptoms, diagnosis. Some of the month had missing information of names, antibiotics and precaution. An interview with Infection Preventionist Employee E13 on August 15, 2024, at 1:45p.m. confirmed there was no documentation evidence of an effective antibiotic stewardship program. At the time of survey ending August 16, 2024, the facility failed to demonstrate their actions designed to implement an effective antibiotic stewardship program which includes a system to effectively monitor antibiotic use and prevent inappropriate use of antibiotics. The facility did not submit any antibiotic steward ship program policy and did not submit evidence of ASP program including surveillance, tracking, and analysis which was requested to the infection preventionist, the director of nursing and Nursing Home administrators every day of the survey. 28 Pa. Code 211.10(d) Resident care policies 28 Pa Code 211.12 (d)(1)(5) nursing Services