

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  03/13/2025
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 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>38735</p> <p>Based on review of documentation and staff interview, it was determined the facility failed to ensure residents were provided a Notification of Medicare Non-coverage (NOMNC) and an Advanced Beneficiary Notice of Non-coverage (ABN) for three of three residents reviewed (Resident 91, Resident 151, Resident 152).</p> <p>Findings include:</p> <p>Review of facility documentation for three residents revealed a Notification of Medicare Non-Coverage (NOMNC) was not provided to Resident 91, Resident 151 or Resident 152.</p> <p>Review of facility documentation for three residents revealed Advanced Beneficiary Notice of Non-Coverage (ABN) was not provided to Resident 91, Resident 151 or Resident 152.</p> <p>Interview with the Administrator in Training, Employee E8, on March 13, 2025 at 1:42 p.m. revealed that the facility could not locate a NOMNC or an ABN notification for Resident 91, Resident 151 or Resident 152.</p> <p>Interview with the Nursing Home Administrator on March 13, 2025, at 2:00 p.m. confirmed that the facility could not provide evidence that Resident 91, Resident 151 or Resident 152 received a NOMNC or an ABN notification.</p> <p>28 Pa. Code 201.18(b)(1) Management</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
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<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48347</p> <p>Based on review of facility policy, facility documents, clinical records, and interview with staff; it was determined the facility failed to develop a comprehensive care plan and interventions to address Resident R75 diagnosis of alcohol dependency. This failure resulted in actual harm to Resident R75 who was observed with signs/symptoms of intoxication, transferred to hospital, and diagnosed with alcohol intoxication which required intravenous therapy for one of 38 residents reviewed. (Resident R75)</p> <p>Findings include:</p> <p>Review of facility policy titled Person Center Care Plan revised October 24, 2022, revealed the center must develop and implement a baseline person centered care plan within 48 hours of admission for each resident that includes instructions needed to provide effective and person-centered care that meet professional standards of quality care. A comprehensive person-centered care plan must be developed for each patient and must describe the following services that are to be furnished, any service that would otherwise be required but not provided due to patients exercise of rights including the rights to refuse treatment, any specialized service or specialized rehabilitative service that the center will provide as a result of the PASRR (Pennsylvania Pre-Admission Screening) recommendations. Care plans will be communicated to appropriate staff, patient, patient representative and family. Reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments, and as needed to reflect the response to care and the changing needs and goals; and documented.</p> <p>Review of Resident R75's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses of alcohol dependence, Bipolar Disorder (condition in which a person has periods of depression, and periods of being extremely happy), history of transient ischemic attack (stroke), alcohol cirrhosis of liver (severe scarring of the liver), generalized anxiety disorder, and difficulty walking.</p> <p>Review of Resident R75's quarterly Minimum Data Set assessment (MDS- assessment of resident care needs) dated August 5, 2024, revealed the resident had a BIMS (Brief Interview of Mental Status) score of 15, indicating the resident was cognitively intact. Continued review of the MDS revealed the resident had no upper or lower extremities impairment and was independent with ambulation.</p> <p>Review of Resident R75's nursing notes dated September 17, 2024, (late entry 5:46 p.m.) revealed, the resident was found to have a small water bottle with clear liquid in the bottom that smelled like alcohol. The resident did say (he/she) was drinking. (Resident R75) refused to say how (he/she) obtained the alcohol. (He/she) stated every one here was buying it.</p> <p>Further review of same Resident R75's nursing note dated September 17, 2024 revealed, [Resident R75] was hitting elevator, slurring (his/her) speech, order to send to ED (emergency room ) or evaluation was obtained however [Resident R75] refused to go with ambulance. She/he refused to allow NHA (Nursing Home Administrator) and DON (Director of Nursing) ro (sic) search room. MD (physician) was made aware and nursing. Plan of care ongoing.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident's R75's clinical record revealed that there was not evidence that a care plan was developed related to the resident's diagnosis of alcohol dependency and/or following the incident on September 17, 2024 in which the resident admitted obtaining and drinking alcohol.</p> <p>Review of nursing note dated October 2, 2024, at 9:00 a.m. revealed, the resident met with the administration team to address a drinking incident that occurred over the weekend. During the meeting, the team discussed the situation in detail, reviewed the impact of the incident and provided the resident with a formal 30-day notice of discharge.</p> <p>Review of Social Service documentation dated October 2, 2024, revealed that Resident R75 had a drinking incident that occurred over the weekend (9/29-9/30, 2024). A 30-day discharge notice was issued to the resident due to endangerment of resident safety related to multiple occasions where resident was found to be visibly intoxicated with verbal aggression towards others.</p> <p>Continued review of nursing notes dated October 3, 2024, at 3:19 p.m. revealed Resident had screamed out in (his/her) room that (he/she) stung by a bee .Patient was slurring (his/her) words and tipsy sitting up in bed. Resident went to bathroom and was tipsy walking to the bathroom. Nursing seen a water bottle hidden under a pillow in (resident) room. When UM (Unit Manager) opened the bottle to smell, you could smell liquor in bottle resident grabbed it from my hand and stated that is non of your business leave it alone. Patient than began to state '[resident] needs benadryl bc (because) [resident] is allergic .' [Physician] called an notified of above and gave verbal order to send resident out to hospital . Prior to resident leaving (he/she) agreed to a room search and 3 more empty water bottles were found smelling of vodka, and empty mouth wash were also found.</p> <p>Review of Resident R75's hospital discharged records dated October 4, 2024, revealed the resident's primary diagnosis of alcohol intoxication. The resident blood alcohol (BAC) level 276 (BAC as mg/dL: for every 100 milliliters (or 1 deciliter) of blood, there are 200 milligrams of alcohol) at admission. Patient received IV (intravenous fluids) at admission. Patient received IV (intravenous fluids).</p> <p>Review of Resident R75's clinical record revealed a care plan for substance abuse/alcohol dependence which was not initiated until October 6, 2024. The goal of the care plan was for the resident to have decreased episodes of alcohol seeking behaviors. Interventions included to build resident relapse prevention skills by helping identify early signs of relapse, observe for signs and symptoms of withdrawal for detox, reassess resident to determine if substance use can be effectively managed in the current setting initiated, monitor conditions that may contribute to substance use, monitor medications for potential contribution to substance and or drug interaction.</p> <p>Interview with Licensed nurse, Employee E9 on March 13, 2025, at 9:50 a.m. who was on duty during the drinking incident that occurred over the weekend (9/29-9/30, 2024) per Social Service documentation on dated October 2, 2024, revealed that she has no knowledge of the resident diagnosis of alcohol abuse.</p> <p>Interview with Nursing aide, Employee E7 on March 13, 2025, at 10:05 a.m. This employee confirmed that she was familiar with Resident R75. Nursing aide, Employee E7 stated [she/he] is very nice and always happy. Employee E7 denies having any knowledge of Residents R75 history of alcohol abuse and denies any awareness of Resident R75 observed intoxicated with any behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Nursing aide, Employee E8 confirmed that she was familiar with Resident R75. Employee E8 denied any knowledge of Resident R75's diagnosis of alcoholism and of incidents relating to the resident being intoxicated.</p> <p>Interview with Director of Nursing (DON), Employee E2 and Regional Nurse, Employee E5 on March 13, 2025, at 9:00 a.m. confirmed that the resident's care plan was initiated after October 4, 2024. DON, Employee E2 confirmed that the care plan was updated to reflect the resident's alcohol abuse after the last known occurrence on October 4, 2024.</p> <p>The facility failed to develop a comprehensive care plan and interventions to address Resident R75's diagnosis of alcohol dependency. This failure resulted in actual harm to Resident R75 who was found intoxicated on three different occasions while at the facility from September 17, 2024 through October 2, 2024. Resident R75 was transferred to the hospital, diagnosed with alcohol intoxication and required intravenous therapy on October 2, 2024.</p> <p>Refer to F689</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa Code 211.10(d) Resident care policies</p> <p>28 Pa. Code 211.12 (c)(d)(1) Nursing Services</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48347</p> <p>Based on the review of facility documentation, clinical records, hospital records, and interviews with resident and staff, it was determined the facility failed to provide appropriate staff supervision and failed to complete a thorough assessment of the resident environment for Resident R75 with a diagnosis of alcohol dependency. This failure resulted in actual harm to Resident R75 who was found with symptoms of intoxication, transferred to the hospital, diagnosed with alcohol intoxication with a blood alcohol level of 276 mg/dL and required intravenous therapy for one of 38 residents reviewed. (Resident R75)</p> <p>Findings include:</p> <p>Review of Resident R75's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses of alcohol dependence, Bipolar Disorder (condition in which a person has periods of depression, and periods of being extremely happy), history of transient ischemic attack (stroke), alcohol cirrhosis of liver (severe scarring of the liver), generalized anxiety disorder, and difficulty walking.</p> <p>Review of Resident R75's Minimum Data Set assessment (MDS- assessment of resident care needs) dated August 5, 2024, revealed the resident had a BIMS (Brief Interview of Mental Status) score of 15, indicating the resident was cognitively intact. Continued review of the MDS revealed that the resident had no upper or lower extremities impairment and was independent with ambulation.</p> <p>Review of Resident R75's nursing notes dated September 17, 2024, (late entry 5:46 p.m.) revealed the resident was found to have a small water bottle with clear liquid in the bottom that smelled of alcohol. The resident did say (she/he) was drinking. (She/he) refused to say how (resident) obtained the alcohol. (Resident) stated everyone here was buying it. [Resident R75] was hitting elevator, slurring (his/her) speech order to send to ED (emergency room ) or evaluation was obtained however [Resident R75] refused to go with ambulance. (Resident) refused to allow NHA (Nursing Home Administrator) and DON (Director of Nursing) to (sic) search (resident) room. MD (physician) was made aware and nursing. Plan of care ongoing.</p> <p>Review of Resident's R75's clinical record revealed that there was not evidence that a care plan was developed related to the resident's diagnosis of alcohol dependency and/or following the incident on September 17, 2024 in which the resident admitted obtaining and drinking alcohol.</p> <p>Review of nursing note dated October 2, 2024, at 9:00 a.m. revealed the resident met with the administrator team to address a drinking incident that occurred over the weekend. During the meeting, the team discussed the situation in detail, reviewed the impact of the incident and provided the resident with a formal 30-day notice of discharge.</p> <p>Review of Social Service documentation dated October 2, 2024, revealed that Resident R75 had a drinking incident that occurred over the weekend (9/29-9/30, 2024). A 30-day discharge notice was issued to the resident due to endangerment of resident safety related to multiple occasions where resident was found to be visibly intoxicated with verbal aggression towards others.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R75's nursing notes from September 2024 through October 2024 revealed no documented evidence of verbal aggression toward other residents related to the use of alcohol.</p> <p>Review of Resident R75's nursing notes dated October 3, 2024, at 3:19 p.m. revealed Resident had screamed out in (her/his) room that (resident) stung by a bee .Patient was slurring (her/his) words and tipsy sitting up in bed. Resident went to bathroom and was tipsy walking to the bathroom. Nursing seen a water bottle hidden under a pillow in (resident) room. When UM (Unit Manager) opened the bottle to smell, you could smell liquor in bottle resident grabbed it from my hand and stated that is non of your business leave it alone. Patient than began to state (she/he) needs benadryl bc (because) (she/he) is allergic . [Physician] called an notified of above and gave verbal order to sent resident out to hospital . Prior to resident leaving (she/he) agreed to a room search and 3 more empty water bottles were found smelling of vodka, and empty mouth wash were also found.</p> <p>Review of facility documentation submitted to the State survey agency dated October 3, 2024, revealed that Resident R75 was observed by staff on 10/3/24, slurring (her/his) speech, arguing aggressively with staff and other residents. [Her/his] behavior appeared impaired. [Resident] refused to allow search of [her/his] room and belongings. [Resident] did state that someone from the kitchen brings in the alcohol. [She/he] refused to mention the name of the staff member. A facility investigation was conducted which included interview with Resident R75, other residents and all dietary staff and in-house staff. The resident refused room searches. Resident R75 does not receive any visitors but frequently orders from an online store and online meal service. The investigation was inconclusive of how resident received alcohol.</p> <p>Review of hospital discharged records dated October 4, 2024, revealed the resident primary diagnosis of alcohol intoxication. The resident's blood alcohol (BAC) level 276 (BAC as mg/dL: for every 100 milliliters (or 1 deciliter) of blood, there are 200 milligrams of alcohol) at admission. Patient received IV (intravenous fluids).</p> <p>Review of <a href="http://www.consumersshield.com/articles/blood-alcohol-level-chart">www.consumersshield.com/articles/blood-alcohol-level-chart</a> A revealed, a blood alcohol consumption level of 0.40%+ is typically lethal, while 0.25%-0.39% can cause coma or death. Severe alcohol poisoning at these levels may shut down vital functions.</p> <p>Review of Resident R75's care plan revealed, a care plan for substance abuse/ alcohol dependence was not developed until October 6, 2024.</p> <p>Interview with Nursing Home Administrator (NHA), Employee E1 and Director of Nursing, Employee E2 on March 12, 2025, at 1:35 p.m. confirmed there were no reported incidents or investigation relating to September 17, 2024, and during the weekend of October 2, 2024, that pertained to Resident R75 being observed intoxicated.</p> <p>Interview with Resident R75 on March 11, 2025, at 10:15 a.m. revealed the resident was aware of the thirty-day discharge notice and that she/he has been working with social work and care provider to aid in this transition. [She/he] looking forward to moving on with [her/his] life and eager to leave the facility.</p> <p>Interview with Resident R75 on March 13, 2025, at 9:05 a.m. revealed that she/he has had no problems with the administration and or any rules/ regulations of the facility. Resident R75 confirmed placing orders online for food and products.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's clinical record revealed no documented evidence the facility implemented interventions to monitor and supervise Resident R75's environment for the presence and consumption of alcohol.</p> <p>The facility failed to provide appropriate staff supervision and failed to complete a thorough assessment of the resident environment which resulted in actual harm to Resident R75 who was found with symptoms of intoxication, transferred to the hospital, diagnosed with alcohol intoxication with a blood alcohol level of 0.27% and required intravenous therapy.</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa Code 211.10(d) Resident care policies</p> <p>28 Pa. Code 211.12 (c)(d)(1) Nursing Services</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>39344</p> <p>Based on review of personnel records and interviews with staff, it was determined that the facility failed to complete annual performance reviews for nurse aide staff as required for five of five nurse aide personnel files reviewed (Employees E5, E6, E21, E22 and E23).</p> <p>Findings include:</p> <p>Review of Employee E5's personnel filed revealed that the employee was hired by the facility on June 13, 2023, as a nurse aide. Continued review revealed than an annual performance review had not been completed for the employee.</p> <p>Review of Employee E6's personnel filed revealed that the employee was hired by the facility on July 16, 2004, as a nurse aide. Continued review revealed than an annual performance review had not been completed for the employee.</p> <p>Review of Employee E21's personnel filed revealed that the employee was hired by the facility on October 2, 2006, as a nurse aide. Continued review revealed than an annual performance review had not been completed for the employee.</p> <p>Review of Employee E22's personnel filed revealed that the employee was hired by the facility on April 1, 2020, as a nurse aide. Continued review revealed than an annual performance review had not been completed for the employee.</p> <p>Review of Employee E23's personnel filed revealed that the employee was hired by the facility on June 23, 2021, as a nurse aide. Continued review revealed than an annual performance review had not been completed for the employee.</p> <p>Interview on March 13, 2025, at 1:03 p.m. with the Director of Nursing, revealed that annual performance reviews for Employees E5, E6, E21, E22 and E23 had not been completed at any time during 2024 or 2025.</p> <p>28 Pa. Code 201.19(2) Personnel policies and procedures</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>39344</p> <p>Provide and implement an infection prevention and control program.</p> <p>Based on review of clinical records, observations, review of facility policy and interview with staff, it was determined that the facility failed to implement special contact precautions, enhanced barrier precautions and practice infection control practices related to residents reported to be under precautions for care for four of eight residents reviewed. (Resident R15, Resident R7, Resident 69 and Resident 75)</p> <p>Findings include:</p> <p>Review a facility policy titled Special Contact and Droplet Precautions Revised dated February 24, 2025, revealed special contact and droplet precautions will be used to prevent transmission of infectious organisms that can be spread via pathogens that spread through the air or by direct person to person respiratory transmission. An example of a disease requiring special droplet and contact precaution is SARS / COVID. Further review of this policy revealed anyone entering the room must wear proper personal protective equipment (PPE) including respiratory protection N95 respirator, gowns, and gloves prior to entering the room of those who require special contact and droplet precautions.</p> <p>Review of facility policy, Transmission Based Precautions dated revised July 11, 2024, revealed, Enhanced barrier precautions (EBP) are designed to reduce the transmission of multidrug-resistant organisms (MDRO) in facilities. Continued review revealed that, EBP consists of the use of gowns and gloves for high-contact care activities which include . changing briefs and wound care.</p> <p>Review of facility policy Covid - 19 Patient Placement and Roaming Considerations revised November 2024, revealed patients who test positive for COVID 19 will be placed in special contact and droplet precautions If Never mind Patients who are diagnosed with COVID 19 can be removed from transmission based precautions when the following criteria are met at least 10 days have passed since since symptoms first appeared, 24 hours have passed since last fever, and symptoms have improved, results are negative from at least two consecutive tests.</p> <p>Review of Center for Disease Control and Prevention (CDC) policy titled Enhanced Barrier Precaution in Skilled Nursing Facilities dated November 15 2025, revealed the focus on the use of gown and gloves during high contact resident care activities that have been demonstrated to result in the transfer of MDROS (Multi drug resistant organisms) to hand to hand and clothing of healthcare personnel, even if blood and bodily fluid exposure is not anticipated. Enhanced barrier precautions are recommended for residents known to be colonized or infected with an MDRO as well as those at increased risk of MDRO acquisition, examples are residents with wounds and indwelling medical devices. Healthcare personnel are to wear specific PPE during high contact resident care activities which includes dressing, bathing and providing hygiene, changing linens, changing briefs device care and wound care.</p> <p>Review of facility provided document Covid line list ( a list of all residents in the facility who have an active diagnosis of COVID) provided to at survey entrance revealed there were ten residents with diagnosis of Covid. Resident R15 was included on the covid line list. This resident tested positive for COVID on March 7, 2025 and currently on contact and droplet precautions.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation of Licensed nurse, Employee E4 on March 10, 2025 at 10:31 a.m. was observed entering Resident</p> <p>R15's room during med pass. Resident R15's door was viewed with a sign on the door which indicated that the resident in this room was under special contact and airborne precaution. The sign instructed anyone entering the room must wear PPE including gown, gloves, and mask and keep the door closed. Employee E4 was observed entering Resident R15's room with no PPE on.</p> <p>Interview with licensed nurse, Employee E4 at time of the above observation confirmed that Resident R15 had a diagnosis of COVID and is on contact precautions. Employee E4 stated that the precaution required was only for washing hands.</p> <p>Second observation of Licensed nurse, Employee E4 on March 10, 2025 at 10:40 a.m. revealed Employee E4 reentering Resident R15's room with only an N95 mask, no gown , no gloves.</p> <p>Observation of wound care treatment to Resident R7 being provided by a hospice Licensed nurse, Employee E16 and Nursing aide, Employee E17 on March 11, 2025 at 10:40 a.m. revealed both Employee E16 and E17 only wearing gloves and no gown.</p> <p>Interview with Employee E16 at time of the above observation confirmed that the resident was on enhanced barrier precaution but only as a facility precaution. PPE is not warranted for this resident</p> <p>Interview with Unit Manager, Licensed nurse, Employee E10 on March 11, 2025 at 10:53a.m. regarding enhanced barrier precaution, specifically the indication for need to wear PPE , revealed that if there is no infection and residents are not on an antibiotic then PPE is not necessary unless they are actually providing care on an effective wound. Ask if all residents with visual enhanced barrier signs on the doorway have infections and or antibiotics and or folic catheter unit manager replied it is a facility protocol as a precaution for the signs being on the doors.</p> <p>Review of facility documentation, COVID-19 line listing, revealed that Resident R69 tested positive for COVID-19 on March 6, 2025.</p> <p>Clinical record review for Resident R69 revealed a care plan, dated initiated March 6, 2025, for COVID-19 positive infection, with interventions including contact and droplet precautions.</p> <p>Continued record review for Resident R69 revealed a physician's order, dated March 10, 2025, for droplet and contact isolation precaution for COVID-19 infection.</p> <p>Clinical record review for Resident R75 revealed a progress note, dated March 8, 2025, at 1:44 p.m. that the resident tested negative for COVID-19.</p> <p>Observation, on March 10, 2025, at 12:18 p.m. revealed that a sign indicating Special Contact and Droplet Precautions was posted on the door of Resident R69 and Resident R75's room. Continued observation revealed Employee E24, nurse aide, took Resident R69 and Resident R75's lunch trays from the lunch truck, then proceeded to enter the residents' room and set up the lunch trays for the residents. Employee E24, nurse aide, then left the room and walked down the hallway. Employee E24, nurse aide, wore only a surgical mask, and did not don an N95 respirator, a gown, or perform hand hygiene while delivering the lunch trays to Residents R69 and R75.</p> <p>(continued on next page)</p>		

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  03/13/2025
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)
F 0880  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	28 Pa Code 211.10((d) Resident care policies  28 PA Code 211.12(d)(1)(3) Nursing services

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  03/13/2025
NAME OF PROVIDER OR SUPPLIER  Hopkins Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8100 Washington Lane Wyncote, PA 19095	
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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38735</p> <p>Based on observation, review of the facility policy and staff and resident interview, it was determined that the facility failed to ensure that call bells were available and operable for resident use for two of 38 residents observed residents. (Residents R63 and R39)</p> <p>Findings include:</p> <p>Review of facility policy, Call Lights, revised June 6, 2021, revealed that all Genesis Healthcare patients will have a call light or alternative communication device within their reach at all times when unattended.</p> <p>Interview with Resident R63 in room [ROOM NUMBER], on March 10, 2025, at 11:25 a.m. revealed that he does not use the call bell much and he pointed to the call bell which was wound around the bedrails. It was noted that the other end of the cord was cut off and laying on the floor, and the severed cord attached to the plug was in the wall jack. When the button was pushed it did not activate. Further observation of the light on the ceiling outside her door revealed that it did not light after pressing the button multiple times.</p> <p>Interview with the Licnensed nurse, Employee E26, on March 10, 2025, at 11:30 a.m revealed that the call bell was not working.</p> <p>Interview with Resident R39 in room [ROOM NUMBER], on March 10, 2025, at 11:40 a.m. revealed that she had an adaptive call bell that she could blow into to call for help. She said that it had been broken sometime the night before and had not been working all day.</p> <p>Follow-up interview with Resident R39, on March 11, 2025, at 10:30 a.m. revealed that her call bell was still not working.</p> <p>Interview with the Unit Manager on the second floor, Licensed nurse, Employee E10, on March 11, 2025, at 10:35 a.m. revealed that Resident R39's call bell was not working, and the facility had ordered the parts for this specialty call bell because none of their sister facilities had this type of call bell.</p> <p>28 Pa. Code 205.67(j) Electric requirements for existing construction</p> <p>28 Pa. Code 201.18 (b)(1) Management</p> <p>28 Pa Code 211.12(d)(1)(3)(5) Nursing services</p>		

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  03/13/2025
NAME OF PROVIDER OR SUPPLIER  Hopkins Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8100 Washington Lane Wyncote, PA 19095	
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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46993</p> <p>Based on observations and review of facility provided documentation, it was determined facility did not ensure to provide a sanitary, comfortable environment for residents for four out of 11 rooms observed on third floor unit (Room# 300, 302, 304, 305)</p> <p>Findings include:</p> <p>Review of facility provided policy 'Accommodation of Needs,' revised on February 1, 2023, indicates that residents have a right to a safe, clean, comfortable, and homelike environment, and housekeeping and maintenance services necessary to maintain a sanitary , orderly and comfortable interior.</p> <p>Observations on March 10, 2025 at 9:39 a.m., room [ROOM NUMBER], revealed food crumbs on floor, and a strong urine odor.</p> <p>Further observations on March 10, 2025 at 11:56 a.m., revealed dry yellow substance under chair on floor, urinal on floor.</p> <p>Further observations on March 10, 2025 of room [ROOM NUMBER], at 9:45 a.m., revealed mustard packets on floor under bedside table, empty soda can on floor, sweetener packets, lotion cap on floor, papers and a brief bag on floor.</p> <p>Further observations on March 10, 2025 at 9:50 a.m., room [ROOM NUMBER], revealed food crumbs under bed, snack wraps on floor, dirty and dusty bedside table.</p> <p>Findings confirmed at the time of the observations with housekeeping Employee, E18.</p> <p>28 Pa Code 201.14 (a) Responsibility of licensee</p>		