

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 08/07/2025
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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policies, staff interviews, and observations, it was determined that the facility failed to maintain personal privacy for one of 18 residents reviewed (Resident R80). Findings include: On August 4, 2025, at approximately 11:00 a.m., the first-floor conference room began to experience a ceiling leak. Nursing Home Administrator, Employee E1, and three maintenance staff were notified. Upon arriving at room [ROOM NUMBER], it was observed that the sink was clogged and overflowing onto the bathroom floor. Standing water was present on the floor and leaking into the first-floor conference room. While three maintenance staff were working on the plumbing issue, Resident R80 was receiving morning care. It was observed that Resident R80's privacy curtain only covered a quarter of the resident's bed, failing to provide full privacy. On August 5, 2025, at 12:52 p.m., an interview with Resident R80 revealed that the resident only has half of the privacy curtain in (her/his) room. Resident R80 further stated that for the first nine months of (her/his) admission, the facility never provided a privacy curtain. Resident R80 explained, When my roommate has guests and I have a Nursing Assistant (NA) providing care at my bedside, I request that her guests leave because my curtain does not close, which prevents me from having full privacy during care. Resident R80 reported that (she/he) received half of a curtain approximately five months ago and, at that time, requested a full curtain, as the half curtain did not provide (her/his) with adequate privacy. On August 6, 2025, at 2:26 p.m., an observation conducted with the Administrator, Employee E1, confirmed that R80 had only half of a curtain and that there was a lack of privacy in her room. 28 Pa. Code 201.29(a) Resident Rights.</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
---	-------	-----------

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 08/07/2025
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and resident and staff interviews, it was determined that the facility failed to maintain the facility in a clean, safe, comfortable and homelike condition in one of two nursing floors (2nd floor nursing unit). Findings include: On August 4, 2025, at approximately 11:00 a.m., the first-floor conference room began to experience a ceiling leak. The surveyor notified the Administrator, Employee E1, and three maintenance staff were sent to investigate the plumbing issue on the second floor. Upon arriving at room [ROOM NUMBER], it was observed that the sink was clogged and overflowing onto the bathroom floor. Standing water was present on the floor and leaking into the first-floor conference room. On August 5, 2025, at 12:52 p.m., an interview with Resident R80 revealed that her bathroom sink had leaking pipes, which caused water to drip onto the floor and resulted in water damage to both the floor and the first-floor conference room ceiling. She reported that this issue had reoccurred approximately three to four times over the past two months. Resident R80 stated that she had notified the maintenance staff. On August 7, 2025, at approximately 2:00 p.m., the first-floor conference room began to experience a ceiling leak again. The surveyor notified the Administrator, Employee E1. It was determined that the sink in room [ROOM NUMBER] was leaking once more. At that time, a Certified Nursing Assistant was providing care to Resident R80 and reported that the sink leak continues to occur. Over the past two months, the sink has been clogged twice, resulting in repeated damage to the bathroom floor. Administrator confirmed the bathroom leak. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) (3) Management.</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 08/07/2025
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 0656</p> <p>Level of Harm - Minimal harm or potential for 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>Based on review of clinical records, observations, and staff interviews, it was determined that the facility did not complete a comprehensive care plan for two of 18 residents reviewed (Resident R42 and R2). Findings include: Review of facility policy Prosthetics and Orthotics dated December 16, 2024 revealed that Nursing will routinely: inspect the prosthesis and/or orthostatic device to determine if it fits correctly and is functioning as intended, or if it is in need for repair. Evaluate skin/mucus membrane that comes in contact with the prosthesis to ensure it is free of abrasion, wounds, or irritation. Review of clinical record for Resident R2 revealed that the resident had diagnosis including acquired absence of right leg below knee, acquired absence of right leg below knee, and peripheral vascular disease. Review of clinical record dated June 27, 2025, revealed that the resident that while giving shower nurse aide noted new skin issue. Resident was noted stage 2 pressure injury to left lateral inner knee. Resident stated it was from his prostheses being too tight and mentioned therapy had recently adjusted it. Inspected both left and right leg as resident is bilateral below knee amputation and used prosthetics on both lower extremities. Review of care plan for Resident R2 dated June 4, 2025 revealed that the resident was at risk for skin breakdown related to decreased mobility and left and right knees amputation. Care plan interventions prior to June 27, 2025 revealed no care plan interventions for skin check prior to or after wearing prosthesis, evaluating the proper fit of the prosthesis and the proper functioning of the prosthesis. Interview with Lead Wound Care Nurse, Employee E12, on August 7, 2025, at 1:15 p.m., confirmed that staff should check residents' skin at the location where prosthesis touches the skin before and after placing the prosthesis or periodically if resident wears the prosthesis independently. Employee E12 also confirmed that the care plan intervention for Resident R2 did not include interventions for skin check prior to or after wearing prosthesis, evaluating the proper fit of the prosthesis and the proper functioning of the prosthesis. Review of resident R42's clinical record revealed that the resident was admitted to the facility on March 20, 2017, with diagnoses including legal blindness. Interview with the facility Director of Nursing and Regional Nurse, Employee E3, conducted on August 7, 2025, at approximately 2:30 p.m. confirmed that a care plan to address communication in relation to legal blindness for Resident R42; there were no focus, interventions, and goals care planned for Resident R42's diagnosis of Legal Blindness. 28 Pa. Code 211.12(d)(1) 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 08/07/2025
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on the observations, interview with staff, it was determined that the facility failed to administer medications according to professional standards of practice three of three medication administrations observed. (Residents R59, R39 and R50) Findings Include: According National Library of Medicine (Operated by the United States federal government, a biomedical library and a national resource for health professionals, scientists, and the public) five rights of medication use: the right patient, the right drug, the right time, the right dose, and the right route-all of which are generally regarded as a standard for safe medication practices. Observation of the Medication Administration by Employee E13, Licensed Practical Nurse for Resident R59 on August 6, 2025, at 9:00 a.m. revealed that the nurse prepared the medication for Resident R59, walked into resident room and administered the medication. The nurse did not verify the resident's first and last name, date of birth or name at the door prior to entering resident's room to administer the medication. Continued observation revealed that the nurse gave Resident R59 her eye drops walked to the other side and took vitals signs of Resident R39. On her way back to the medication cart she collected the eye drops from Resident R59 and placed it in the medication cart. Employee E13 did not complete Resident R59's medication administration prior to checking Resident R39's vital signs. Employee E13 also did not ensure that the resident was administering the eye drop appropriately as ordered by the physician. Observation of the Medication Administration by Employee E13, Licensed Practical Nurse for Resident R39 on August 6, 2025, at 9:19 a.m. revealed that that the nurse prepared the medication for Resident R39, walked into resident room with the medications in hand, and administered the medication. The nurse did not verify the resident's first and last name, date of birth or name at the door prior to entering resident's room to administer the medication. Review of physician order for Resident R59 revealed no documented evidence that the resident had an order for self-administering the medication. Review of clinical record for Resident R59 revealed no documented evidence that the resident was assessed for medication safety for medication self-administration and a care plan was developed for self-administration. Observation of the Medication Administration by Employee E14, Licensed Practical Nurse for Resident R50 on August 6, 2025, at 9:32 a.m. revealed that the nurse prepared the medication walked into resident R50's room called resident's first name and administered the medication. The nurse did not verify the resident's last name, date of birth, residents arm band or name at the door prior to entering resident's room to administer the medication. Interview with Employee E14 on August 6, 2025, at 9:45 a.m. stated staff should ask resident's first name, last name and date of birth to ensure the right patient before medication administration or check residents arm band for the same information if resident could not respond appropriately. Employee E14 confirmed that right patient right was not followed. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1)(2)(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 08/07/2025
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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical records, and staff interview, it was revealed that the facility failed to modify protein needs and implement interventions consistent with the resident's assessed needs and current professional standards of practice of nutritional status as it relates to pressure ulcer prevention for one of 18 residents reviewed (Resident R82). Findings include:Review of facility policy titled, Estimating Protein Needs dated 2015, revealed that residents at risk for pressure ulcers require 1.2g/kg (grams per kilogram).Review of Resident R82's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses including Aphasia (affected communication), obesity, dysphasia (impairment in the production of speech), and multiple sclerosis (disease that causes breakdown of the protective covering of nerves), hemiplegia (paralysis of one side of the body).Review of Resident R82's Nutrition assessment dated [DATE], revealed a protein factor of 1.0 g/kg. Continued review revealed a progress note by the Dietitian, Employee E4, which indicated a protein prescription of 86 grams daily (utilizing 1.0 g/kg protein factor). A review of Resident R82's clinical record, Braden Scale for Predicting Pressure Sore Risk, dated May 24, 2025, revealed that the resident score was 17, indicating the resident was at risk for developing pressure ulcers. Review of the resident's clinical record revealed no documented evidence that the resident's protein needs were re-assessed after the resident was assessed at risk for developing pressure ulcers.Interview with the Registered Dietitian, Employee E4, conducted on August 7, 2025, at 9:38 a.m. confirmed the above-mentioned findings. Continued interview revealed that according to facility documentation, Resident R82 should have received at least 1.2g/kg to ensure acceptable parameters of nutritional status. 28 Pa. Code 211.5 (f) Clinical records 28 Pa. Code 211.6 (d) Dietary services 28 Pa. Code 211.12 (c)(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 08/07/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the observations, and staff interviews, it was determined that the facility did not provide pharmacy services according to professional standards of practice for one of four residents reviewed. (Resident R50) Findings Include:Review of drug information for Fish oil revealed that Omega-3-acid ethyl [NAME] capsules are a prescription medicine used along with a low fat and low cholesterol diet to lower very high triglyceride (fat) levels in adults. Take omega-3-acid ethyl [NAME] capsules whole. Do not break open, crush, dissolve, or chew omega-3-acid ethyl [NAME] capsules before swallowing. If you cannot swallow omega-3-acid ethyl [NAME] capsules whole, tell your healthcare provider. You may need a different medicine.Review of physician order for Resident R50 dated March 8, 2024 revealed an order for Omega-3 Fatty Acids Capsule 1000 MG, give one capsule by mouth one time a day.Observation of the Medication Administration by Employee E14, Licensed Practical Nurse for Resident R50 on August 6, 2025, at 9:32 a.m. revealed that the nurse removed Fish oil capsule from the container, opened the capsule by cutting it, poured the liquid into apple sauce. Observation of the capsule shell prior to discarding revealed that there were still some medication liquid left in the capsule.Interview with the Director of Nursing on August 7, 2025 at 11 a.m. confirmed that the medication could not be open and the resident should be getting a different form of the medication.28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1)(2)(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 08/07/2025
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical records, professional standards of practice and interviews with facility staff, it was determined that the facility failed to ensure that it was free of medication error rate of five percent or greater for three of four residents observed during medication administration (Resident R50, Resident R59 and R39). Findings include Observation of the Medication Administration by Employee E13, Licensed Practical Nurse for Resident R59 on August 6, 2025, at 9:00 a.m. revealed that the nurse gave Resident R59 her eye drops walked to the other side and took vital signs of Resident R39. On her way back to the medication cart she collected the eye drops from Resident R59 and placed it in the medication cart. Employee E13 did not complete Resident R59's medication administration prior to checking Resident R39's vital signs. Employee E13 also did not ensure that the resident was administering the eye drop appropriately as ordered by the physician including the dosage and correct application. Review of physician order for Resident R59 dated July 8, 2025, revealed an order for Artificial Tears Ophthalmic Solution 1 %, instill 1 drop in both eyes two times a day. Review of physician order for Resident R59 revealed no documented evidence that the resident had an order for self-administering the medication. Review of clinical record for Resident R59 revealed no documented evidence that the resident was assessed for medication safety for medication self-administration and a care plan was developed for self-administration. Review of drug information for Major Pharmaceuticals Fish oil revealed that Omega-3-acid ethyl [NAME] capsules are a prescription medicine used along with a low fat and low cholesterol diet to lower very high triglyceride (fat) levels in adults. Take omega-3-acid ethyl [NAME] capsules whole. Do not break open, crush, dissolve, or chew omega-3-acid ethyl [NAME] capsules before swallowing. If you cannot swallow omega-3-acid ethyl [NAME] capsules whole, tell your healthcare provider. You may need a different medicine. Review of physician order for Resident R50 dated March 8, 2024 revealed an order for Omega-3 Fatty Acids Capsule 1000 MG, give one capsule by mouth one time a day. Observation of the Medication Administration by Employee E14, Licensed Practical Nurse for Resident R50 on August 6, 2025, at 9:32 a.m. revealed that the nurse removed Fish oil capsule from the container, opened the capsule by cutting it, poured the liquid into apple sauce. Observation of the capsule shell prior to discarding revealed that there were still some medications liquid left in the capsule. Review of physician order for Resident R39 dated March 21, 2025 revealed an order for Aspercreme Lidocaine External Cream 4 % (Lidocaine HCl) Apply to bilateral thighs topically two times a day for pain. Further review of physician order revealed an order for Aspercreme Lidocaine External Patch (Lidocaine) apply to lower back topically one time a day for lower back pain and remove per schedule. Observation of the Medication Administration by Employee E13, Licensed Practical Nurse for Resident R39 on August 6, 2025, at 9:19 a.m. revealed that the nurse removed two patch consistent with Aspercreme Lidocaine External Patch from resident's bilateral knee and applied new patch to bilateral knee. Continued observation revealed that there was no topical application of patch to lower back. Interview with Employee E13 on August 6, 2025, at 9:25 a.m. stated there should be wearing schedule for the patch, usually on for 12 hours and off for 12 hours and the previous day evening shift staff should be removing it. Employee stated she was from agency and was not familiar with facility protocol and did not provide further details of the observation. The facility incurred a medication error rate of 14.81 %. Pa Code:211.12(d)(1)(2)(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 08/07/2025
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 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>Based on resident council interview, staff interviews, review of facility policy and reviews of the established mealtime schedule, it was determined that the facility failed to ensure a nourishing snack was provided when 14 hours are between a substantial evening meal and breakfast on the three of three nursing units. (First, Second, and Third Floors). Findings include: Findings include: A review of facility policy titled Snacks, Revised September 2017, revealed that bedtime snacks will be provided foal I residents. The dining services department will assemble and deliver to each unit the individually planned snack items and bulk snack items to be offered at bedtime. Continued review revealed that Nursing Services is responsible for delivering the individual snacks to the identified residents and for offering evening snacks to all other residents. A review of the established meal schedule for the residents revealed that the supper meal was scheduled for 4:45 p.m. on the first and second-floor nursing units; 5:00 p.m. on the third-floor nursing unit; and 5:15 p.m. on the third-floor nursing unit; and that the breakfasts meal the following morning was offered at 7:45 a.m. the following day. On August 6, 2025, at 10:30 a.m., a resident council was held with nine alert and oriented residents (R27, R42, R78, R50, R23, R46, R45, R65, R3). The residents reported that nourishing snacks were not offered at bedtime. They stated that they eat dinner at 4:45 p.m. and become hungry later in the evening. On August 7, 2025, at approximately 11:25 a.m., an interview was conducted with the Dietary Director, Employee E8, who stated that she maintains a list of all diabetic residents who are assigned afternoon and nighttime snacks. The remaining residents receive a regular snack, such as a cookie or milk. Night snacks are prepared and sent out by dietary staff; however, it is the responsibility of the nursing staff to offer them to all residents. On August 7, 2025, at approximately 11:30 a.m., an interview was conducted with the dietician, Employee E4. The interview revealed that dinner is served at 4:45 p.m. in the second-floor dining room, and breakfast is offered at 7:45 a.m. to the same residents, resulting in a 15-hour gap between these two meals. On August 7, 2025, at approximately 3:00 p.m., the Director of Nursing, Employee E2, and the Regional Nurse, Employee E3, confirmed that night snacks are delivered by the kitchen staff; however, it is unknown if the nursing staff are actually offering them to residents. 28 Pa. Code: 201.14(a) Responsibility of license</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 08/07/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record, facility policy, observations, and interviews with staff, it was determined that the facility failed to exercise proper infection control techniques for one of two nursing units observed (Second Floor Nursing Unit) and two of four medication administration pass observed. (Resident R39 and Resident R59) Findings include: Review of facility policy titled Enhanced Barrier Precautions, revised December 16, 2024, revealed Standard Precautions, Enhanced Barrier Precautions (EBP) will be used (when Contact Precautions do not otherwise apply) for novel or targeted [NAME]- drug resistant organism (MDROs). To reduce the risk of transmission of epidemiologically important microorganism by direct or indirect contact. On August 4, 2025, at approximately 10:00 a.m., Resident R80 was observed receiving care from Nursing Assistant, Employee E5, who was not wearing any Personal Protective Equipment (PPE), despite EBP signage posted on the resident's door. An observation on August 4, 2025, at 10:10 a.m., on the second-floor nursing unit, room [ROOM NUMBER], revealed Enhanced Barrier Precaution (EBP) signage posted on the door; however, no appropriate disposal container was available inside the resident's room to allow for removal of PPE. The Unit Manager, Employee E9, was interviewed regarding why Resident R80 had EBP signage on the door. A review of the clinical record did not reveal any documentation indicating that the resident required EBP. Employee E9 then consulted with the Nurse Practitioner, Employee E10, who was also not aware of the reason for the signage. An interview was then conducted with the Infection Preventionist, Employee E11, who reported that Resident R80 has a wound and that staff should be wearing EBP when providing care to the resident. Employee E11 confirmed that staff was not wearing EBP gown. On August 5, 2025, at 12:52 p.m., an interview with Resident R80 revealed that this was the first time a nursing aide had worn a PPE gown while providing care. The resident stated that, in the past, nursing staff would only wear gloves when providing care. Observation of the Medication Administration by Employee E13, Licensed Practical Nurse for Resident R59 on August 6, 2025, at 9:00 a.m. revealed that the nurse gave Resident R59 her eye drops walked to the other side and took vital signs of Resident R39. On her way back to the medication cart she collected the eye drops from Resident R59 and placed it in the medication cart. Employee E13 did not complete Resident R59's medication administration prior to checking Resident R39's vital signs. Employee E13 also did not ensure that the resident was administering the eye drop appropriately as ordered by the physician including the dosage and correct application. Employee E13 did not wash her hands after giving medications to Resident R59 and before taking vital signs for Resident R39. Employee did not use the opportunity to wash her hands after taking vital signs and before collecting eye drop from Resident R59. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(c)(d)(1)(5) Nursing Services</p>		