STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395360	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Germantown Home	6950 Germantown Avenue Philadelphia, PA 19119

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based review of facility documentation, facility policy, clinical records, and interviews with staff, it was determined that the facility failed to ensure that a resident's care plan was revised timely to address ongoing and escalating aggressive behaviors for one of two sampled residents. (Resident R1) Findings include: Review of facility's policy, titled Resident Centered Care Plans revised January 2011, establishes that care plans are person-centered, interdisciplinary, and written in language that is understandable to all involved. The purpose of the care plan is to provide a resident-specific, timely, and comprehensive plan of care that addresses each resident's needs, conditions, impairments, and strengths. Care plans are developed promptly and include measurable goals, specific interventions, and time frames. Importantly, care plans must be updated whenever there are changes in the resident's condition, status, or treatment needs, not only during quarterly reviews. While the interdisciplinary team conducts quarterly reviews to evaluate resident progress, any significant change in a resident's status between meetings triggers a revision or initiation of a new plan by the affected discipline. This policy ensures that care plans remain current, individualized, and reflective of each resident's evolving needs, emphasizing that revisions are required whenever a change in a resident's status occurs to maintain appropriate and timely care. Review of Resident R1's quarterly Minimum Data Set (MDS- a federally mandated assessment tool for all residents), dated September 4, 2025, revealed that Resident R1 was admitted to the facility on [DATE], with diagnoses including dementia (decline in cognitive abilities), seizure disorder (a neurological condition characterized by recurrent seizures), and malnutrition (condition when the body does not receive enough nutrients or calories to function properly).The functional status assessment indicated that Resident R1 was independent with most activities of daily living and usually used a cane from mobility. The brief interview for mental status (BIMS) reflected a score of 10, indicating moderate cognitive impairment Further review of Resident R1's nursing notes dated October 13, 2025, noted that housekeeping staff reported observing Resident R1 raised his cane toward his roommate Resident R2 as if to strike him. Resident R2 was offered a room change but declined.Review of Psychiatric note dated October 19, 2025, documented Resident R1 with increased irritability and physical aggression. Review of nursing note dated October 21, 2025, revealed that staff reported Resident R1 struck a licensed nurse and verbally abused another staff member. On October 26, 2025, Resident R1 was observed swinging his cane toward staff members. Review of nursing notes dated November 1, 2025, revealed that at 6:30 am Resident R1 struck licensed nurse while she was providing care to roommate Resident R2. Continued review of nursing notes dated November 1, 2025, at 7:07 am revealed Resident R1 struct Resident R2 on the hand with his cane. Review of facility incident report revealed that on November 1, 2025, at approximately 7:07 a. m. a nurse heard somebody yelling for help coming from Resident R1's room. When the nurse entered the room, she observed Resident R2 lying in his bed with his right hand raised in front of his face as if to block the strike. Resident R1 was standing at bedside and witnessed striking Resident R2 right hand with his cane. Review of Resident R1's care plan-initiated June 6, 2025, revealed that the resident's care was not reviewed and/or revised until October 27, 2025 was reviewed and the intervention a psychiatric consult was added to the care plan. Interview with Social Service Director, Employee E4 on November 12, 2025, at 1:30 p.m. revealed that Resident R1 was usually pleasant but experienced periods of confusion and occasionally aggression significantly reduced. Employee E4 stated that prior to November 1, 2025, the resident was not considered a behavioral risk and had no documented history of aggressive behaviors. Following the incident on November 1, 2025, the resident's daughter suggested that the resident might suffer from post-traumatic stress disorder PTSD (Post Traumatic Stress Disorder). Employee E4 stated that he was unaware of any PTS diagnosis and confirmed that a PTSD screening had been completed upon a mission with no known diagnosis or identified triggers. He further stated that for the welfare and safety of all the residents , after resident R1 express violent behavior although the resident reported he was defending his roommate the interdisciplinary team determined it was in the residence best interest to be referred to in-patient psychiatric evaluation. Interview with the Director of Nursing, Employee E2, conducted on November 12, 2025, at 2:15 p. m. revealed the facility staff were aware of resident R1's behavior changes and were informally monitoring his aggression. 28 Pa Code 211.12(d)(1)(5) Nursing services