

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395360	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024
NAME OF PROVIDER OR SUPPLIER Germantown Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47975</p> <p>Based on review of facility documentation and interview with staff, it was determined the facility failed to provide timely notice on non-medical coverage (NOMNC) for one of three residents reviewed. (Resident 117)</p> <p>Findings Include:</p> <p>Review of Resident R117's clinical records shows the resident was readmitted to the facility on [DATE].</p> <p>Resident R117 remained at the facility after his last day of coverage was September 2, 2024.</p> <p>Review of the social service note from September 18, 2024 revealed Note Text: Resident Representative, notified on September 18, 2024 of resident's last coverage date of September 3, 2024. Resident Representative informed of right to appeal last coverage date. Resident Representative stated they would like resident to continue working with therapy. Social Services informed Resident Representative that resident will be picked up by rehab on Physical Therapy caseload per rehab Director. Social Services will provide Resident Representative copies of Notice of Medicare Non-Coverage and Advance Beneficiary Notification via email.</p> <p>Interview with facility Social Worker, Employee E12 held September 19, 2024 at 1:38 p.m. confirmed social services relies on an e-mail from the rehab department for the last date of coverage. Employee E12 stated that for Resident R117 they never received the e-mail from the rehab department.</p> <p>The facility failed to issue a Notice of Medicare Non-Coverage (NOMNC) prior to termination of Medicare A services, as required.</p> <p>28 Pa. Code 201.29(f) 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
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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38735</p> <p>Based on observation, clinical record review, and interview with staff and residents, it was determined that the facility did not ensure that resident assessments accurately reflected resident status related to use of a urinary catheter and discharge status for two of 38 records reviewed (Residents R50 and R178).</p> <p>Findings include:</p> <p>Observations of Resident R50 conducted on September 17, 2024, at 11:30 a.m. confirmed that the resident had no urinary catheter present. Interview with the resident at this time revealed that the catheter had been in use because of my wound on my backside but that it had been discontinued due to the progress of the wound healing.</p> <p>Review of clinical documentation for Resident R50 revealed that she was admitted to the facility on [DATE], and had diagnoses of pressure ulcer of the sacral region, stage 4 (stage 4 pressure ulcers extend through the skin and fat layers into the muscle, and may extend to the bone), and muscle weakness. Also revealed was a physician order to discontinue the resident's urinary catheter, dated June 15, 2024.</p> <p>Continued review revealed that an MDS assessment (Minimum Data Set- a periodic assessment of resident care needs) was signed by the Registered Nurse Assessment Coordinator (RNAC), Employee E15, on August 9, 2024. In section H, Bladder and Bowel, Employee E15 recorded that the resident was utilizing an indwelling urinary catheter.</p> <p>Interview with RNAC, Employee E15 on September 20, 2024, at 12:15 p.m. confirmed that the catheter had been coded in error.</p> <p>A review of Resident R178's Discharge MDS assessment dated [DATE], revealed that he was admitted to the facility on [DATE], and discharged on [DATE], and that Section A2105 Discharge Status revealed that Resident R178 was coded 04, Short-Term General Hospital (Acute Care).</p> <p>Review of Resident 178's clinical record revealed an August 4, 2024, progress note documenting that the resident is being discharged to home after successful stay for management of status post hospitalization for positive Covid 19 virus, urinary tract infection and sepsis.</p> <p>Interview with the Assistant Administrator, Employee E3 on September 20, 2024, at 11:30 a.m. revealed that Resident R178 had been discharged home with his family and that the MDS was coded in error as the resident did not discharge to the hospital.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 211.5(f) Clinical Records</p>		

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<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38735</p> <p>Based on review of facility policy, observation, clinical record review, and interview with staff and residents, it was determined that the facility did not develop a comprehensive care plan related oxygen use for one of 35 records reviewed (Resident R167).</p> <p>Findings include:</p> <p>Review of Resident Centered Care Planning policy revised 2023, revealed that based on a comprehensive, interdisciplinary assessment, the care team will address individualized resident needs to include physical, psychosocial, functional, recreational, spiritual, educational and communication needs.</p> <p>Review of clinical documentation for Resident R167 revealed that she was admitted to the facility on [DATE], and had diagnoses of asthma and obstructive sleep apnea. A physician's order was obtained on January 29, 2024, which stated O2 (oxygen) at 2LPM (liters per minute) via nasal cannula at bedtime for hypoxia (low blood oxygen levels). Review of the resident's care plan revealed that no care plan had been developed for the resident use of oxygen.</p> <p>Observations of rResident R167 conducted on September 17, 2024, at 10:45 a.m., revealed that the resident was wearing her oxygen cannula, with the concentrator running at 2 liters per minute. She stated that I wear it every night until I get up.</p> <p>Interview with Employees E1, the Nursing Home Administrator, and E2, the Director of Nursing, on September 20, 2024, at 2:00 p.m., revealed that it is the expectation of the facility that the care plan for all residents utilizing oxygen should reflect that use.</p> <p>28 Pa. Code 211.11(d) Resident care plan.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44882</p> <p>Based on review of facility policy, observation, clinical record review and interview with staff and residents, it was determined that the facility did not revise and update the resident's plan of care related to urinary catheter use for one of 35 records reviewed (Resident R50).</p> <p>Findings include:</p> <p>Review of Resident Centered Care Planning policy revised 2023, revealed that based on a comprehensive, interdisciplinary assessment, the care team will address individualized resident needs to include physical, psychosocial, functional, recreational, spiritual, educational and communication needs.</p> <p>Observations of Resident R50 conducted on September 17, 2024, at 11:30 a.m. confirmed that the resident had no urinary catheter present. Interview with the resident at this time revealed that the catheter had been in use because of my wound on my backside, but that it had been discontinued due to the progress of the wound healing.</p> <p>Review of clinical documentation for Resident R50 revealed that she was admitted to the facility on [DATE], and had diagnoses of pressure ulcer of the sacral region, stage 4 (stage 4 pressure ulcers extend through the skin and fat layers into the muscle, and may extend to the bone), and muscle weakness. Also revealed was a physician order to discontinue the resident's urinary catheter, dated June 15, 2024.</p> <p>Continued review revealed that a care plan which stated, I have an indwelling catheter for .sacral wound management, which was created on December 24, 2023, and revised on February 2, 2024. The Last Care Plan Review Completed of the overall plan of care was dated on August 21, 2024.</p> <p>Interview with Employees E1, the Nursing Home Administrator, and E2, the Director of Nursing, on September 20, 2024, at 2:00 p.m., confirmed that the care plan had not been updated to reflect the resident's current urinary status at the time of the care plan review.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38735</p> <p>Based on review of facility policy, observation, clinical record review and interview with staff and residents, it was determined that the facility did not ensure that services were provided to maintain hearing and vision for two of 35 records reviewed (Residents R53 and R142).</p> <p>Findings include:</p> <p>Review of Guidelines for Use of the Consult Tracking Log policy reviewed April 2022, revealed that a physician's order for a consult is entered in the electronic record as needed. A progress note should be written in PCC for the reason of consult by the nurses. Unit Clerk will review the order in PCC and schedule the appointment, notify the resident representative with the date and time, schedule the escort if needed, and transportation. Unit clerk or designee will write a note under consultation confirming the appointment, responsible party notification and transportation notification.</p> <p>In an interview with Resident R142 on September 17, 2024, at 1:45 p.m., the resident stated that they had checked her hearing a while ago and told her she was getting a hearing aide, and that she never got one.</p> <p>Review of clinical documentation for Resident R142 revealed that she was admitted to the facility on [DATE], and had diagnoses of cognitive communication deficit. Further review revealed a March 16, 2023, audiology consult which recommended a hearing aide evaluation and that the patient agreed.</p> <p>Review of Resident R142's physician orders revealed an April 15, 2024, order for Audiology and Ear, Nose and Throat (ENT) consult, evaluation, treatment as ordered by physician services, over a year later. Continued review of Resident R142's record revealed that the ENT consultation was done May 14, 2024, which indicated treatment was partial debridement of both ears and recommended debridement of both ears and an Audiology consult.</p> <p>Interview with Unit Clerk, Employee E14, on September 19, 2024, at 1:50 p.m. revealed that she was still following up with Audiology for that status of the hearing aids for Resident R142, and that Resident R144 is also waiting for Audiology for his hearing aids.</p> <p>Review of Resident R144's clinical documentation revealed that he was admitted on [DATE], with diagnosis to include having a stroke with aphasia (comprehension and communication (reading, speaking, or writing) disorder resulting from damage or injury to the specific area in the brain). Review indicated that Resident R144 had an ENT consult on April 6, 2023, which stated that the patient was cleared for hearing aids. A May 8, 2023, Audiology consult revealed hearing loss in both ears and recommended an ENT consult. Further review of Resident R144's clinical record revealed that the ENT consult was not done until April 3, 2024, which recommended an Audiology evaluation. An August 21, 2024, social services note indicated that an amplifier was added to Resident R144's room phone and that he was to be seen by Audiology on the next September 5, 2024, visit. No further documentation was available as to the status of Resident R144's hearing aids.</p> <p>(continued on next page)</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Unit Clerk, Employee E14, on September 19, 2024, at 1:50 p.m. revealed that she had just called Audiology about the status of Resident R144's hearing aids and that they were to get back to her.</p> <p>Review of clinical documentation for Resident R53 revealed that she was admitted to the facility on [DATE], and had diagnoses of type 2 diabetes with diabetic retinopathy of the right eye.</p> <p>In an interview with Resident R53 on September 18, 2024, at 12:07 p.m., she stated that an outside care company is paying for my glasses. I've had my appointment back in May and I'm waiting for my new glasses. My friend bought the ones I'm wearing. The resident stated that she required bifocals to correct both near and far vision, but that her current pair were non-prescription reading glasses.</p> <p>Continued review of the clinical record revealed a nursing note signed by Registered nurse, Employee E16, on May 16, 2024, which stated Resident seen in house by optometry, N/O (new order) for new prescription glasses.</p> <p>Review of a consultation note from the consultant optometrist, Employee E17, dated May 15, 2024, revealed that it included an updated prescription for eyeglasses and stated that glasses were required and to encourage full-time use for distance and reading.</p> <p>Review of a document titled Eyeglass Dispense Log which listed all residents who received new glasses between January 20, 2024, and September 19, 2024, revealed that the resident was not documented as having received her eyeglasses.</p> <p>In an interview with the Director of Nursing, Employee E2, on September 19, 2024, at 1:34 p.m., she stated that the outside service paying for the glasses has a process, and that the prescription was sent to them. A subsequent interview with Employee E2 at 1:56 p.m. confirmed that the resident's new eyeglasses had not yet been delivered.</p> <p>No evidence was provided that the facility attempted to follow up with the service to ensure that the needed glasses were delivered in a timely manner.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>38735</p> <p>Based on staff interviews and a review of employee credentials, it was determined that the facility failed to employ a qualified director of food and nutrition services (Employees E9).</p> <p>Findings include:</p> <p>An interview on September 17, 2024, at 10:30 a.m. with Employee E4, Food Service Director (FSD), revealed that his responsibilities included oversight of ordering, receiving, storing, preparation and service of food. Further interview with the FSD confirmed that he was not currently a certified dietary manager (CDM); or a certified food manager (CFM); or had a national certification for food service management and safety from a national certifying body; or had an associate's or higher degree in food service management or hospitality from an accredited institution; and that she had not received frequently scheduled consultations from a qualified dietitian.</p> <p>A review of Employee E4's credentials revealed that Employee E4 did not meet the statutory qualifications of a director of food and nutrition services.</p> <p>During an interview on September 19, 2024, at 11:30 a.m. with the Administrator, the FSD's personnel file was reviewed, and his qualifications were discussed which revealed he had been working at the facility for many years, was promoted to FSD over a year ago and was not a Certified Dietary Manager or Certified Food Manager. The Administrator confirmed that the FSD had not completed these requirements.</p> <p>The Nursing Home Administrator was unable to provide evidence that the FSD was Certified, and therefore unqualified to direct the dietary department.</p> <p>28 Pa. Code 211.6(c)(d) Dietary services</p> <p>28 Pa Code 201.18(e)(1)(6) Management</p>		