

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024
NAME OF PROVIDER OR SUPPLIER Deer Meadows Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8301 Roosevelt Boulevard Philadelphia, PA 19152	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923</p> <p>Based on review of facility policies, facility documents, clinical records review, and resident and staff interviews, it was determined that the facility failed to ensure that residents are free of misappropriation of resident property for one out of 10 residents reviewed. (Resident R1).</p> <p>Findings include:</p> <p>Review of facility policy Abuse Prevention last revised October 2020, indicated The facility prohibits the mistreatment, neglect, and abuse of residents/patients and misappropriation of resident/patient property by anyone including staff, family , friends, etc. The facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect mistreatment, and/or misappropriation of property.</p> <p>Review of the facility information submitted to the state Survey Agency dated May 15, 2024, indicated that certified nursing aide, Employee E3 misappropriated Resident R1's property by ripped off her magazine picture that were hanging outside of her door and side wall and trashing them on May 15, 2024, at approximately 9:10 p.m. An investigation was initiated, police was called, nursing aide, Employee E3 was suspended.</p> <p>Review of admission record indicated Resident R1 was admitted to the facility on [DATE], with diagnoses that included bipolar disorder, anxiety disorder, personal history of healed traumatic, spinal stenosis lumbar region without neurogenic claudication, morbid (severed) obesity due to excess calories.</p> <p>Review of Resident R1's Minimum Data Set (MDS- periodic assessment of care needs), dated February 29, 2024, indicated the resident had a BIMS (Brief Interview for Mental status) score of 15 which indicated that the resident's cognitive status for daily decision making was intact.</p> <p>Review of the comprehensive care plan dated November 30, 2020 documented Resident R1 has accusatory behaviors where Resident R1 accusing nursing of not given medication timely and perceives things differently that they are, verbal abusive behaviors towards staff, rejection of care due to ineffective coping skills and bipolar, verbal altercation with nursing aids, [Resident R1] was witnessed by another resident pouring ice on another resident, [Resident R1] verbally threatened another resident who gets meds first.</p> <p>(continued on next page)</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A physician order dated December 28, 2021, for the Resident R1 to be paired care at all times.</p> <p>Nursing notes written by the License nurse, Employee E4 documented on May 15, 2024, at 7:55 p.m. 7:58 p.m. 8:00 p.m. 8:09 p.m. that Resident R1 became verbally abusive towards nursing aide, Employee E3 and Resident's behavior was escalating, and supervisor was made aware. At 10:54 p.m. this same night, the License nurse Supervisor on duty, Employee E8 notified the on-call nurse practitioner to send the Resident R1 to the hospital for psychiatric evaluation. Resident R1 refused.</p> <p>An interview was held with the Resident R1 on May 31, 2024, at 9:40 a.m. who reported that on May 15, 2024, during the evening shift Resident R1 was waiting for her medication at the nursing station on unit C and nurse aide, Employee E3 interrupted Resident R1 and the License nurse, Employee E4. Resident R1 and nurse aide, Employee E3 had a negative relationship prior to this event. Then later that evening Resident R1 went for her smoke break and returned and observed that the nursing aide, Employee E3 ripped off the outside magazine posters that were very important to the resident When Resident R1 confronted nurse aide, Employee E3 for ripping off her posters it escalated to Employee E3 kicking Resident R1 into left knee, throwing away her slipper. Resident R1 reported that she/he did not refuse the skin body assessment.</p> <p>On May 31, 2024, at approximately 11:00 a.m. the Footage Ground Camera #29 revealed the following timeline of events:</p> <p>At 19:52 p.m. Resident R1 by the nursing station</p> <p>At 19:58 p.m. Resident R1 propelling back into her room</p> <p>At 8:20 p.m. to 8:44 p.m. Resident R1 goes back in and out of her room.</p> <p>At 9:10 p.m. Employee E3 is ripping out few posters outside of the Resident R1 room and leaving the unit C.</p> <p>At 9:22 p.m. Resident R1 comes out of her room and propels off the unit C.</p> <p>At 9:33 p.m. Employee E3 comes back and removes more posters off the Resident's R1 door and trashes them and goes toward the nursing unit.</p> <p>At 9:47 p.m. Resident R1 returns to her room and takes pictures of her door. And goes towards nursing station.</p> <p>At 9:57 p.m. Resident R1 goes towards nurse aide, Employee E3 and tries to throw things (snacks) at Employee E3. Employee E3 tries to remove himself from Resident R1. Resident R1 continues to attack.</p> <p>At 10:00 p.m. Resident R1 goes off the unit C and then at 10:03 p.m. the supervisor Employee E8 comes on the unit.</p> <p>There was no camera observation of Employee E3 kicking the Resident R1 into her left knee.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A witness statement from Employee E3, dated May 16, 2024, and taken by the Director of Nursing, indicates that Employee E3 tore down Resident R1's posters, which were hanging outside her door, because Resident R1 was verbally abusive towards Employee E3 during the evening shift, causing Employee E3 to become upset. Employee E3 did not kick Resident R1.</p> <p>The witness statement dated May 16, 2024, of Employee E4, the licensed nurse observing and documenting Resident R1's behaviors on the evening of May 15, 2024, indicates that Employee E4 did not see Employee E3 kicking Resident R1.</p> <p>A telephone interview was conducted on May 31, 2024, at 12:15 p.m. with Employee E4, the licensed nurse covering C unit at the time of the incident on May 15, 2024. At approximately 7:00 p.m. Resident R1 became angry while waiting for her medication, as another resident was receiving medication before her. Employee E3 intervened and asked Resident R1 to be patient. Resident R1's behavior escalated to verbal abuse towards Employee E3 throughout the evening. Employee E3 did not verbally abuse Resident R1. To manage the situation, Employee E4 called the on-call services, supervisor and the nurse practitioner ordered a psychiatric evaluation for Resident R1; however, Resident R1 refused. Employee E4 did not witness the physical altercation between Resident R1 and Employee E3, as she was on the other side of the hallway.</p> <p>On May 31, 2024, at approximately 2:00 p.m., an interview was conducted with the Administrator, who confirmed that nurse aide, Employee E3 was placed on administrative leave and, following the conclusion of the investigation, was terminated because the facility substantiated the incident of mental abuse. The Administrator further reported that, although Resident R1 refused the full body assessment, the nurse was able to observe the left knee after the incident, where Resident R1 had received an injury. The nurse noted an old purple-yellowish bruise on her left knee, which did not corroborate the allegations made.</p> <p>28 Pa Code 211.12(c)(d)(1)(2)(5) Nursing services</p> <p>28 Pa. Code: 211.10 (c)(d) Resident Care Policies</p> <p>28 Pa Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa Code 201.18(a)(b)(1)(e)(1) Management.</p> <p>28 Pa Code 201.29(a)(j) Resident rights.</p>		