STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395425	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deer Meadows Rehabilitation Center	8301 Roosevelt Boulevard Philadelphia, PA 19152

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record, facility documentation, facility policy, and staff interviews, it was determined the facility failed to ensure that all interventions to prevent fall incidents were in place after Resident R48 was transfer into bed, resulting in actual harm to Resident R48 who fell out of bed and sustained a fractured jaw for one of three residents reviewed for falls. (Resident R48) Findings include: Review of facility policy Fall Prevention and Management, revised 2023, revealed an Avoidable Accident is interpreted as an accident occurred because the facility failed to: - Identify environmental hazards and/or assess individual resident risk of an accident, including the need for supervision and/or assistive devices; and/or - Evaluate and analyze the hazards and risks and eliminate them, if possible, or if not possible, identify and implement measures to reduce the hazards/risks as much as possible; and/or - Implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible, and if not, reduce the risk of an accident; and/or - Monitor the effectiveness of the interventions and modify the care plan as necessary, in accordance with current professional standards of practice Review of Resident R48's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that include Cerebral Ischemia (insufficient blood flow and oxygen to the brain, which can lead to cell death or irreversible damage), legal blindness, and Anxiety disorder. Review of Resident R48's physician orders, dated December 09, 2024, revealed an order for fall mat to both sides when resident is in bed, move from bedside when out of bed. Review of Resident R48's quarterly Minimum Data Set (MDS- mandated assessment of a resident's abilities and care needs), dated October 03, 2025, revealed Resident R48 had a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. Review of documentation submitted to the State Survey Agency on January 11, 2025, revealed on January 10, 2025, the nurse aide, Employee E19 was assisting Resident R48 with evening care. After nurse aide, Employee 19 transferred resident to bed she took the wheelchair away from the side of the bed towards the door in resident's room to make space for her to assist resident with evening care. Resident was placed at center of the bed. Then suddenly Employee E19 heard the noise and observed the resident lying on the floor. Upon arrival, the charge nurse observed resident lying on the floor beside [his/her] bed. Resident R48 was observed bleeding from [his/her] mouth. Resident was then transferred to ER (Emergency Room) and diagnosed with closed fracture of maxillary bone (break on the upper jawbone). Review of facility investigation, dated January 10, 2025, revealed the charge nurse was alerted by the nurse aide that Resident R48 had a fall in [resident] room. Resident R48 was observed laying on the ground and his/her mouth bleeding. The nurse aide confirmed that she just transferred resident from wheelchair to bed and while she was putting away the chair when Resident R48 fell. Further review of facility investigation revealed a witness statement from agency nurse aide, Employee E19, on January 13, 2025, which indicated the floor mats were not on the floor at the time of the fall. Employee E19 also stated I was still trying to get [resident] ready for bed. After I finish, then I will put the floor mat on the floor before leaving the (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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	room. Surveyor efforts to conduct phone interview with agency nurse aide, Employee E19 were unsuccessful. Interview conducted on October 23, 2025, at 12:30 p.m. with Assistant Director of Nursing, Employee E13, confirmed Resident R48 had an order for floor mats to be in place while Resident R48 was in bed. The facility failed to ensure floor mats were in place after Resident R48 was transferred into bed and as indicated in the resident's care plan which resulted in actual harm to Resident R48 who fell out of bed and sustained a fracture of the jaw. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, facility policy, resident and staff interviews, it was determined that the facility failed to maintain the facility in a clean and homelike condition in one of eight nursing units (Dementia Unit 2nd floor). Findings include: Facility Policy titled Housekeeping Operational Manual revised on 11/2024, revealed under Bed Washing and Disinfecting it stated to control odor, to prevent the spread of infections and bacteria and to ensure maximum cleanliness and sanitation for the individual resident. Bed disinfecting is performed on a monthly basis (in conjunction with complete room cleaning).Observations on September 29, 2025, at approximately 11:54 a.m. indicated that Unit Manager, Employee E10, confirmed a strong and heavy odor of urine on the dementia unit between rooms [ROOM NUMBERS].Observations on September 30, 2025, at 12:48 p.m. on the dementia unit near room [ROOM NUMBER] revealed a strong odor of urine. Licensed Nurse Employee E8 confirmed the strong and heavy odor of urine near room [ROOM NUMBER] and in the small hallway leading into the dementia unit.On September 30, 2025, at 12:48 p.m., an interview with a housekeeping staff member, Employee E9, confirmed a strong and heavy urine odor. Employee E9 reported that room [ROOM NUMBER] had been cleaned, but suggested that the flooring may be saturated with urine and may need to be replaced. A certified nursing assistant, Employee E11, reported that she/he had changed the resident residing in room [ROOM NUMBER]. The Unit Manager, Employee E10, also confirmed the urine odor and stated that she would request that the mattress be inspected and replaced if necessary.On October 1, 2025, at 1:06 p.m., there was no detectable urine odor near or inside room [ROOM NUMBER]. The Unit Manager, Employee E10, reported that the mattress in room [ROOM NUMBER] had been replaced.28 Pa. Code 201.18(e)(2.1) Management

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of clinical records, interview with staff and resident, it was determined that the facility failed to ensure that MDS (Minimum Data Set) a federally required resident assessment completed at a specific interval) was completed accurately for one of thirty-five residents reviewed. (Resident R143) Findings include: Rearview of Resident R143's clinical record revealed that Resident R143 was admitted to the facility on [DATE], with diagnosis of but not limited to Chronic Obstructive Pulmonary Disease.Review of Resident Review of Resident R143's quarterly MDS dated [DATE], revealed that section B0200, Hearing was coded as ADEQUATE Review of hearing evaluation dated July 25, 2025, revealed that Resident 143 was seen for an audiometric hearing evaluation. Further, the hearing evaluation revealed moderate - severe hearing loss in both ears. Further review of Resident R143's clinical record, revealed a care plan for Communication Problem r/t Hearing deficit Ability to hear initiated on January 30, 2025. Observation of Resident R143 conducted on September 29, 2025, at 1:15PM revealed that resident was in bed, alert, awake and responsive to surveyor. Further observation during interview with resident revealed that resident was not able to hear surveyor very. Interview with Resident R143 conducted at the time of the observation revealed that Resident R143 was hard of hearing. Further, Resident R143 asked the surveyor to speak louder so she can hear. Further interview with resident revealed that she does not have a hearing aid and that the staff had to talk louder to her in order for her to hear them properly. Interview with Director of Social Worker Employee E5 and Social Worker Assistant Employee E6, conducted on October 23, 2025, at 10:42AM revealed that the MDS dated [DATE], section B0200 (Hearing) was completed by Social Worker Assistant Employee E6 who was a new employee. Further, Employee E5 confirmed that the MDS section B0200 was coded erroneously. Further, Employee [NAME] revealed that they will correct the MDS. 28 Pa. Code 211.12(d)(1) Nursing Services

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based ln observation and review of clinical record, it was determined that the facility failed to ensure that a baseline care plan was developed within 48 hours of a resident's admission for one of thirty-five residents observed. (Resident R13)Findings include:Review the facility policy for Care Planning Process and Care Conference with the most recent revision date of March 19, 2025 reveal that under section POLICY: To foster the philosophy of the facility in compliance with federal and state regulations and in accordance with HIPAA regulations, the facility will develop a comprehensive residence center care plan for each resident/patient. the RNAC (registered nurse assessment coordinator)/CRC (clinical reimbursement coordinator) will be responsible for the coordination and implementation of resident care plan. Under section PROCEDURE: #1. an interdisciplinary baseline care plan will be initiated upon admission by the admitting nurse and completed within 48 hours. Review of resident R13's clinical records revealed that resident was admitted to the facility on [DATE], with a diagnosis of but not limited to Obstructive and Reflux Uropathy. Review of physician's order dated April 30, 2025, revealed an order for Nephrostomy Care Q (every) shift and PRN (whenever needed) Review of Resident R13's MDS (minimum data set- a federally required resident assessment completed at a specific interval) dated August 6, 2025, section C0500 BIMS (brief interview for [NAME] status) summary score was coded 13 suggesting that resident was cognitively intact. section H (Bladder and Bowel), H0100 (Appliances), A. revealed that resident had an indwelling catheter (including suprapubic catheter and Nephrostomy tube). Review of Resident R13's clinical record revealed no baseline care plan for nephrostomy tube. Observation conducted on September 29, 2025, at 1:13 PM, revealed that Resident R13 was in bed awake, and responsive to surveyor. Further observation revealed that nephrostomy bag was lying on resident's bed. interview with Charge Nurse Employee E7 conducted at the time of the observation revealed that resident has nephrostomy. Interview with DON (Director of Nursing) Employee E2 conducted on October 1, 2025, at 1:16PM, confirmed that there was no baseline care plan. 28 PA Code 211.10(c) Resident care policies 28 PA Code 211.12(d)(1)(2) Nursing service

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on review of facility policies, clinical record reviews and interviews with staff, it was determined that the facility failed to develop a person-centered comprehensive care plan related to dementia care and/or activities for one of 35 residents reviewed (Resident R55).Findings include:Review of facility policy, Care Planning Process and Care Conference dated revised on March 19, 2025, revealed The resident/patient centered care plan development will include the following interdisciplinary team members: Resident Nurse Assessment Coordinator/ Clinical Reimbursement Coordinator (RNAC/CRC), Nursing, Rehabilitation, Dietician, Food Service staff member, social worker, nursing assistant, physician(if applicable), Activities, resident and resident representative. Further review revealed Procedure: Include such initial needs/problems such as ADL's, falls, skin tears, risk for skin breakdown, nutritional status, behaviors, pacemakers, anticoagulants, psychotropic medication use, etc. Include a care plan related to the resident's primary diagnosis. Review of Resident R55's clinical record revealed resident admitted to facility on July 30, 2025, with a diagnosis of Acute Kidney Failure, and Dementia (progressive degenerative disease of the brain).Review of Resident R55's Quarterly MDS (Minimum Data Set- a mandatory periodic resident assessment tool) dated August 6, 2025, revealed that resident has BIMS (Brief Interview for Mental Status) of 6, indicating that resident has a severe cognitive impairment. Observation of Resident R55 on September 29, 2025 at 11:35pm, revealed resident sitting alone in chair, in front of television. Observation of Resident R55 on September 29, 2025 at 1:35pm, revealed resident sitting alone in chair, in front of television. Observation of Resident R55 on September 30, 2025 at 12:30pm, revealed resident sitting alone in chair, in front of television. Interview with Employee E13, Nursing Assistant on September 30, 2025 at 1:20pm, revealed that there isn't a lot for [Resident R55] to engage and participate in. No activities on a 1:1 basis. [Resident R55] regularly sits close to nursing station in front of television.Review of Resident R55's comprehensive care plan, last revised September 26, 2025, revealed no evidence of care plan in place for dementia care or activities. Interview on September 30, 2025, at 2:20 p.m. Employee E2, Director of Nursing, confirmed that no care plan was developed for Resident R55 related to his Dementia Care and/or activities. 28 Pa Code 211.10(d) Resident care policies28 Pa Code 211.12(d)(5) Nursing services

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, and interviews with residents, and staff, it was determined that the facility failed to provide the necessary assistance with activities of daily living (ADLs) to maintain proper grooming for one of the four residents reviewed (Residents R153)Findings include:Review of Resident 153's clinical record revealed the resident was admitted to the facility on [DATE], and had a diagnosis of disorder of muscle, spinal stenosis (abnormal narrowing of the spinal canal that results in pressure on the spinal cord and nerve roots causing pain and numbness in arms and legs),A review of Resident R153's annual Minimum Data Set (MDS- assessment of resident care needs), dated July 20, 2025, indicated a Brief Interview for Mental Status (BIMS) score of 14, reflecting cognitive intact. The functional abilities section of the MDS indicated that Resident R153 requires partial/moderate assistance with showering tasks.A comprehensive care plan dated, June May 02, 2025 indicated an Activity of Daily Living (ADL) goal of bathing needing 1 staff assistance with bathing/showring.An interview was conducted on September 30, 2025, at 10:14 a.m., during which Resident R153 reported, Yesterday, September 29, 2025, was my shower day. At around 11 a.m., a [nurse aide Employee E12], came in. I asked if she was my aide, and she said yes. I then asked when I would be getting my shower. She responded, ?I don't know,' and never came back. She didn't make my bed either. I got tired of waiting and used the sink to bathe on my own.On October 1, 2025, at 10:01 a.m., an interview with the Director of Nursing, Employee E2, confirmed that Resident R153 did not receive a shower as scheduled. 28 Pa. Code 211.10 (d) Resident care policies28 Pa code 211.12.(d)(1)(5) Nursing services

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observation, and staff interviews, it was determined that the facility failed to provide an ongoing program of activities to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for two of eight ([NAME] 2 nursing unit and W1B nursing unit).Findings include:Based on the facility policy titled, Activity Manual last revised on April 2025 revealed Activity program are designed to meet the interest of and support the physical , mental and psychosocial well-being of each resident.During a review of activity calendar on September 29, 2025, at 11:00 a.m. the following activities were scheduled for the Skilled Nursing and Rehab nursing unit:11:00 a.m. Concentration Puzzle -GA1:00 p.m. Room visit2:00 p.m. BingoObservations on September 29, 2025, between 11:35 a.m. and 1:35 p.m., on the W1B nursing unit revealed that Resident R3 was sitting in a wheelchair in front of the TV in the main area.During a review of activity calendar on September 29, 2025, at 1:00 p.m. the following activities were scheduled for the [NAME] 2 nursing unit: 1:15 p.m.- 1:1 room visit 2:00 p.m.- Bingo Observations on September 29, 2025, between 1:15 p.m. and 1:29 p.m. did not show any room visits being conducted on the [NAME] 2 floor. The dining room contained approximately 16 residents seated with two staff members supervising them; no activities were observed.At 1:31 p.m. on the same day, an interview was conducted with the Director of Activities, Employee E15, and the Assistant Activities Director, Employee E16. Both reported that one-on-one room visits were not taking place due to staffing issues and that they were working to address the situation.Observations on September 30, 2025, at 12:30 p.m., on the W1B nursing unit revealed that Resident R3 was sitting in a wheelchair in front of the TV in the main area.An interview was conducted with a nursing aide, Employee E17, on September 30, 2025, at 1:20 p.m., after observing Resident R3 sitting in front of the TV. Employee E17 reported that the facility does not provide many activities and noted that Resident R3 spends most of the time sitting in front of the TV.On October 1, 2025, at 12:37 p.m. and 1:56 p.m. Resident R7 was sitting and eating on TV. When Resident R3 was interviewed she reported that she also likes to color and listen to music.A review of clinical documentation for Resident R19 revealed that she was admitted to the facility on [DATE], with diagnoses of dementia (progressive disease of the brain), muscle weakness, dysphagia, and anemia. A review of the Activity Task records for the past 30 days showed that each day was marked as not applicable. There was no documentation indicating that any one-on-one activities were performed with Resident R3.During a review of activity calendar on October 1, 2025, at 1:32 p.m. the following activities were scheduled for the [NAME] 2 nursing unit: 1:30 p.m.- Gather and Go 2:00 p.m.- Busy hands Club3:00 p.m. - Remember whenOn October 1, 2025, at 1:32 p.m., an interview was conducted with an activity aide, Employee E17, who reported that Gather and Go is an activity designed to gather residents who want to participate in a group activity at 2:00 p.m. However, at the time of observation, all residents were in the dining room, and the activity aide had only three fidget items available for approximately 15 residents. When asked if more fidgets were available, Employee E17 stated no, but noted that there were some pool noodles. She checked the activity closet and confirmed that there were not enough fidgets to conduct a Busy Hands activity.On October 1, 2025, at 1:45 p.m., an interview was conducted with Employee E15, who reported that the facility does have more than three fidgets; however, they are spread across all eight units. The items need to be gathered in order to be made available to residents in the [NAME] 2 unit.28 Pa. Code: 201.18 (b)(3)e(2) Management

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and review of clinical records it was determined that the facility failed to ensure that urinary drainage systems were properly positioned and maintained to prevent urine backflow and urinary tract infection for one of ten residents observed with urinary catheter. (Resident R13)Review of facility policy on Catheter-Foley with a review date of July 2025, section Procedure revealed that under section POLICY: this policy provides the procedure to ensure the safe sterile placement and removal of the folly catheter it also provides guidelines for catheter care and specimen collection from the catheter under section PROCEDURE #V. Completing the Procedure: #2. Position the bag to avoid urine reflux into the bladder, kinking or gross contamination of the bag. Position the bag hanger on the bed frame near the foot of the bed using the clip to secure the drainage tube to the sheet always keep the bag below the level of the bladder to prevent the back flow of urine and decrease the risk of infection. #3 periodic observation of the system should be made to ensure that urine is flowing freely. Review of Resident R13's clinical records revealed that resident was admitted to the facility on [DATE], with a diagnosis of but not limited to Obstructive and Reflux Uropathy. Review of physician's order dated April 30, 2025, revealed an order for Nephrostomy Care Q (every) shift and PRN (as needed) Review of Resident R13 MDS (minimum data set- a federally required resident assessment completed at a specific interval) dated August 6, 2025, section C0500 BIMS (brief interview for [NAME] status) summary score was coded 13 suggesting that resident was cognitively intact. section H (Bladder and Bowel), H0100 (Appliances), A. revealed that resident had an indwelling catheter (including suprapubic catheter and Nephrostomy tube). Observation conducted on September 29, 2025, at 1:132PM, revealed that Resident was in bed awake, and responsive to surveyor. Further observation revealed that nephrostomy bag was lying on Resident's bed. Interview with resident conducted at the time of the observation revealed that the tube was too short. interview with Charge Nurse, Employee E7 conducted at the time of the observation revealed that resident has nephrostomy. Further Charge nurse confirmed that bag was lying flat on Resident R13's bed. Interview with the DON (Director of Nursing) Employee E2 conducted on September 30, 2025, at 11:45AM revealed that the facility did not have a policy specifically for nephrostomy but that they use the policy for Foley Catheter. Interview with DON, Employee E2 conducted on October 1, 2025, at 1:16PM, confirmed that there was no baseline care plan. 28 PA Code 211.12(d)(1)(2)(3) Nursing services 28 PA Code 211.24 Infection control

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and interviews with staff, it was determined that the facility did not ensure that a physician assessment was completed related to unplanned weight loss for one of six residents reviewed (Resident R19).Findings include: Review of clinical documentation for Resident R19 revealed that she was admitted to the facility on [DATE] and had diagnoses of dementia (progressive disease of the brain), muscle weakness, dysphagia and Type 2 diabetes (failure of the body to produce insulin). Review of the resident's weight documentation revealed that on August 8, 2025, the resident weighed 132 pounds. The resident was weighed again on September 1 , 2025, and weighed 123.2 which is a -6.67% Loss. The resident was weighed again a month after on October 7, 2025, the resident weighed 121.8 pounds.Review of Resident R19's Weight Warning Note from September 9, 2025 states, Value: 123.2 triggering for significant weight loss -6.7 x1 mo. Please weigh to confirm. Wt. (weight) loss unplanned. Currently ordered double portions fortified foods, Boost Glucose Control TID. PO intake 50-100% wt. loos of unknown etiology. Continue current POC. Further review of Resident R19's clinical record revealed a Weight Warning Note from October 7, 2025 stating, value: 121.8 triggering for significant weight loss, --7.7%x2 months. Wt. loss unplanned. Wt. stable x1. RP/MD aware. Currently ordered double portions, fortified foods, Boost Glucose Control TID. PO intake 50-100% Agree with current interventions in place. Continue to current POC.There was no indication that a physician evaluated the residents significant weight loss.On October 23, 2025, at 12:15 p.m., an interview with the Assistant Director of Nursing, Employee E13, confirmed that there was no documented assessment of the potential medical causes of Resident R19's recent significant weight loss.On October 23, 2025, at 12:57 p.m., an interview was conducted with the Dietitian, Employee E14, who reported that the facility's protocol for a resident experiencing significant weight loss is to notify the charge nurse, who then notifies the physician to obtain a medical evaluation for the weight loss. Employee E14 stated that she documented in her progress note on October 7, 2025, that both the charge nurse and the physician had been notified.28 Pa. Code: 211.12(d)(5) Nursing services28 Pa. Code: 211.5(f) Clinical records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395425	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deer Meadows Rehabilitation Center	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)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, review of clinical records, 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 one of three residents observed during medication administration (Resident R137).Findings include:On September 30, 2025, 9:40 a.m., observed that Employee E4, a Licensed Nurse, administered to Resident R137, one tablet of Geri-Dryl Allergy Relief by mouth, and one tablet of Benadryl Allergy Oral Tablet 25 MG (Diphenhydramine HCl), by mouth; along with other medications.On September 30, 2025, 10:20 a.m., review of physician orders for Resident R137 indicated an order dated August 8, 2025, for the following: Benadryl Allergy Oral Tablet 25 MG (Diphenhydramine HCl), Give 1 tablet by mouth. No physician order to administer one tablet of Geri-Dryl Allergy Relief by mouth was available.Review of literature indicated as follows: Geri-Dryl is essentially the same as Benadryl. Geri-Dryl contains 25 mg of diphenhydramine hydrochloride in each tablet, acting as an antihistamine. Benadryl Allergy tablet also contains 25 mg of diphenhydramine hydrochloride per tablet and has the same purpose as antihistamine. Because the active ingredient is the same, individuals can expect the same effect, side effects, and drug interactions with both products.On September 30, 2025, 9:40 a.m., observed that Employee E4, a Licensed Nurse, administered to R137, one tablet of Vitamin D Oral Tablet 25 MCG, by mouth. On September 30, 2025, 10:20 a.m., review of physician orders for Resident R137, indicated an order dated December 26, 2023, for the following: Vitamin D Oral Tablet 50 MCG (2000 UT) (Cholecalciferol), give 1 tablet by mouth one time a day for supplement.At the time of the findings, during an interview with the DON, notified the above reports.The facility incurred a medication error rate of 5.88%.28 Pa Code 211.12(d)(1)(2)(5) Nursing Services

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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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on review of facility documentation, review of clinical records, and resident interviews, it was determined that the facility failed to submit complete and accurate information to the State Survey Agency regarding a resident fall for one of three residents reviewed for facility reported incidents (Resident R48). Findings Include: Review of facility reported incident, dated January 11, 2025, revealed nurse aide was assisting Resident R48 with evening care. After CNA transferred resident to bed she/he took the wheelchair away from the side of the bed towards the door in resident room to make space for her to assist resident with evening care. Resident was placed at center of the bed. Then suddenly she heard the noise and observed the resident lying on the floor. Upon arrival, the charge nurse observed resident lying on the floor beside her bed. Resident was observed bleeding from her mouth. Resident was then transferred to ER and diagnosed with closed fracture of maxillary bone. Further review of facility reported incident revealed all fall precautions were in place at the time of Resident R48's fall. Review of Resident R48's physician orders, dated December 09, 2024, revealed and order for fall mat to both sides when resident is in bed, move from bedside when out of bed. Review of facility investigation revealed a witness statement from Employee 19, on January 13, 2025, which revealed the floor mats were not on the floor at the time of the fall. Employee E19 also stated I was still trying to get her ready for bed. After I finish, then I will put the floor mat on the floor before leaving the room. Interview with Director of Nursing, Employee E2, on September 30, 2025 at 11:58 a.m. revealed Resident R48 did not have fall mats in place at the time of fall. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management.