

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/12/2024
NAME OF PROVIDER OR SUPPLIER  Chapel Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  1104 Welsh Road Philadelphia, PA 19115	
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>41471</p> <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on the review of clinical records, interview with staff and resident, it was determined that the facility failed to provide care and services as ordered by the physician for one of three residents reviewed (Resident R2).</p> <p>Findings Include:</p> <p>During interview with Resident R2 on August 12, 2024, at 10:00 a.m. the resident stated that he should be getting ACE wraps to his lower extremity for swelling. Resident stated he was seen by the physician and recommended he wear compression stockings for lower extremity. Resident stated compression stocking was uncomfortable for him so the physician stated he should wear ACE wraps. Resident stated staff did not assist him for putting the ACE wraps on.</p> <p>Observation of the Resident R2 on August 12, 2024, at 10:00 a.m. revealed that the resident was not wearing ACE wraps or compression stockings to the lower extremity. Observation of the resident's room revealed that there was ACE wraps in his bed side drawer. However, there was no compression stocking available in his room.</p> <p>Review of physician's orders for Resident R2 revealed that an order was obtained on July 23, 2024, for compression stockings 15-20 mm Hg knee high closed toe daily for edema (swelling).</p> <p>Review of TAR (Treatment Administration Record) for August 2024 revealed that the order for compression was signed out as administered from August 2, 2024 to August 12, 2024.</p> <p>Interview with Employee E3, Licensed Nurse, on August 12, 2024, at 3:00 p.m. confirmed that the resident not wearing ACE wraps or compression stockings to the lower extremity was ordered by the physician. Employee E3 confirmed that there was no compression stockings in his room.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing services</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 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>41471</p> <p>Based on review of a meal tray test results, review of facility policy and interviews with resident and staff, it was determined that the facility failed to serve foods that were palatable and at proper temperatures for one of eight nursing floors reviewed. (Unit A)</p> <p>Findings include:</p> <p>Review of an undated facility document Resident Tray Assessment Report, revealed that the standard temperature for food items as below:</p> <p>Soup and Hot beverages- greater than or equal to 150-degree Fahrenheit- 3 points; 145-149 degree Fahrenheit -2 points, 140-144 degree Fahrenheit-1 point less than 140 degree Fahrenheit -0 points.</p> <p>Hot Entrees, starch and vegetables- greater than or equal to 130-degree Fahrenheit 3 points; 125-129 degree Fahrenheit -2 points, 120-124 degree Fahrenheit -1 point less than 120 degree Fahrenheit -0 points.</p> <p>All cold food- less than 45 Fahrenheit -3 points, 48-50 degree Fahrenheit -2 points, 51-54 degree Fahrenheit -1 point, greater than 55 degree Fahrenheit- 0 points.</p> <p>Qualitative Assessment: Correct 1 point, Unacceptable -0 point.</p> <p>Fully acceptable-2 point, Need improvement- 1 point, unacceptable- 0 point.</p> <p>Interview with Resident R1 on August 12, 2024, at 10:00 a.m. the resident stated that the hot food was sometimes always served hot. The food taste bad most of the times.</p> <p>Interview with Resident R2 on August 12, 2024, at 10:00 a.m. the resident stated that the hot food was not served hot, she stated she reported this to staff but did not change anything.</p> <p>A test tray on the Unit A nursing unit was performed on August 12, 2024, at 11:49 a.m. with the Dietary staff, Employee E4. During the test tray observation, the food tray for the residents' were prepared at the main kitchen. The test tray temperature was recorded by Dietary staff, Employee E4 in the Unit A nursing unit shortly after all resident trays were prepared. The recorded food temperature for the test tray were as follows:</p> <p>Cold ham and cheese Sandwich- 57.8-degree Fahrenheit.</p> <p>Coleslaw- 61.7-degree Fahrenheit</p> <p>Apple juice- 62.6-degree Fahrenheit</p> <p>Hot Coffee-132.5-degree Fahrenheit</p> <p>Fruit cup- 61.9-degree Fahrenheit</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Employee E4, Dietary Staff on August 12, 2024, at 12:05 p.m. confirmed that the test tray food temperature on August 12, 2024, did not meet the facility hot food temperature standards.</p> <p>28 Pa. Code 201.29(j) Resident rights.</p> <p>28 Pa. Code 211.6(c) Dietary services</p>		

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<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41471</p> <p>Based on clinical record review and resident and staff interview, it was determined that the facility failed to schedule an appointment for outside services in a timely manner for one of 3 residents reviewed (Resident R3).</p> <p>Findings include:</p> <p>During an interview on August 12, 2024, at 10:30 a.m. Resident R3 stated he needed to see an outside provider for his shoulder pain. He stated he was suffering from excruciating pain to the shoulder which he rated at 10/10. He stated he was regularly receiving cortisone shots from an outside provider prior to his admission. Since his admission, he was not seen by an outside provider for an appointment. Resident stated he understand the provider he used to go was far from the facility, however he wanted to see any provider that can treat his shoulder pain and give injection which was effective for him in the community.</p> <p>Resident R3's clinical record revealed an admitted [DATE], with diagnoses that included muscle weakness, osteoarthritis, pain right upper arm and pain and left upper arm.</p> <p>Review of hospital record for Resident R3 on February 14, 2024, revealed that an appointment request to follow up with orthopedic surgery for hip pain.</p> <p>Review of clinical record for Resident R3 revealed no evidence that the resident was seen by an orthopedic provider as recommended by the physician.</p> <p>Resident R3's physician progress note dated August 1, 2024, revealed that nurse stated that resident had Kenalog injection in May which he stated did not work. She had worked to try to get him cortisone injection. Since cortisone injections are not done at the facility. It required transportation (at a cost) for resident to visit ortho to get injections. There was a recommendation to follow up with ortho for right upper arm pain, right left upper arm pain, and osteoarthritis. Continued review of progress note revealed that Currently it is in the hands of administration.</p> <p>Interview with Employee E5 unit clerk on August 12, 2024, at 10:45 a.m. stated there was no appointment made for Resident R3. Employee E5 stated she was waiting for facility administration to respond to make the appointment. Employee E5 stated she could not tell more information to the surveyor and would need to speak to the director of nursing for more information.</p> <p>During an interview with Employee E2, Director of Nursing on August 12, 2024, at 10:45 a.m. could not give a reason for not scheduling the appointment for Resident R3. Employee E2 stated facility had a lot of residents that required services and the facility did not get to the Resident R3's need in a timely manner.</p> <p>28 Pa. Code 211.12(d)(3) Nursing services</p>		