

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  08/05/2025
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)		
F 0842  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.  (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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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of clinical records, review of facility policy and interviews with staff and residents, it was determined that the facility failed to ensure complete documentation of Medication Administration Records for two of 10 residents records reviewed (Resident R1 and R4). Review of Facility policy titled Medication Administration: General Guidelines dated January 2025 revealed The individual who administers the medication dose, records the administration on the resident's MAR (Medication Administration Record) immediately following the medication being given. In no case should the individual who administered the medication report off-duty without first recording the administration of any medication. Further review of policy revealed When PRN medication are administered, the following documentation is provided: a. date and time of administration, dose, route of administration (if other than oral), and, if applicable, the injection site. b. complaints or symptoms for which the medication was given, c. Results achieved from giving the dose and the time results were noted. d. signature or initials of person recording administration and signature or initials of person recording effects. Review of Resident R1's clinical record revealed that resident was admitted to the facility on [DATE] with the diagnosis of end stage renal disease (kidney failure), heart failure (heart doesn't pump blood well) and type 2 diabetes (body can't control blood sugars). Review of Resident R1's physician orders revealed an order obtained on June 24, 2025 for Oxycodone HCL 5 Milligrams (mg) tablet by mouth every 6 hours as needed for chronic pain. Review of Resident R1's narcotic record for Oxycodone HCL 5 mg tablet compared to resident's clinical record revealed on June 28, 2025 at 7:00 pm and June 29, 2025 at 8:00 am narcotic was signed out on narcotic record but no documented evidence of administration to Resident R1's MAR (Medication Administration Record). Interview with Employee E2, Director of Nursing on August 5, 2025 at 10:23 am confirmed medication was signed out on narcotic records but no documented evidence in MAR of administration to resident in Resident R1's clinical record on June 28, 2025 at 7:00pm and June 29, 2025 at 8:00am. Review of Resident R4's clinical record revealed that resident was admitted to the facility on [DATE] with the diagnosis of Chronic Kidney Failure, Cerebral Infarction (obstructed blood flow to the brain), and Heart failure. Review of Resident R4's MDS (Minimum Data Set) Section C- Cognitive Patterns, dated May 18, 2025 revealed resident's has a BIMS (Brief interview for Mental Status) of 15 out of 15, indicating that resident is cognitively intact. Interview with Resident R4 on August 5, 2025 at 12:05 pm, revealed that resident felt that pain management had been adequate and resident did not suffer an increase in pain. Review of Resident R4's physician orders revealed an order obtained on May 22, 2025, for Oxycodone HCL 15mg tablet by mouth every 8 hours as needed for severe pain. Review of Resident R4's narcotic record for Oxycodone HCL 15 mg tablet compared to resident's MAR revealed on June 14, 2025 at 9:00 pm, June 17, 2025 at 9:00 am, June 17, 2025 at 9:00 pm, June 22, 2025 at 9:00 am and June 23, 2025 at unknown time, narcotics were signed out on the narcotic record but no documented evidence of administration to resident in clinical record. Interview with Employee E2, Director of Nursing on August 5, 2025 at 10:30am confirmed medication was signed out on narcotic records but no documented evidence of administration in MAR to Resident R4 June 14, 2025 at 9:00pm, June 17, 2025 at 9:00am, June 17, 2025 at 9:00pm, June 22, 2025 at 9:00am and June 23, 2025 at unknown time. Further revealed that Director of Nursing is responsible to completes periodic, randomized checks to ensure that medications are properly administered to residents however there is no documented evidence of this action. 28 Pa. Code 201.14(a)(b) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(2)(3) Management 28 Pa. Code 201.29(a) Resident rights</p>		