STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395454	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkhouse Rehabilitation and Nursing Center	1600 Black Rock Road Royersford, PA 19468

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 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 upon clinical record review and interview, it was determined the facility failed to ensure an accurate Minimum Data Set Assessment was accurately ompleted for one of 35 residents reviewed (Resident 223). Findings include: Review of Resident 223's Quarterly Minimum Data Set Assessment (MDS - periodic assessment of resident needs) dated April 6, 2025, revealed Resident 223 had a significant weight loss. Review of Resident 223's Weight Summary revealed Resident 223 weighed 144 pounds on March 12, 2025; 131.2 pounds on March 13, 2025, and 142.0 pounds on April 10, 2025. Review of Resident 223's weight change note dated April 10, 2025, revealed RD [registered dietitian] obtained reweight to refute weight change. CBW [current body weight] 142 pounds 4/10. Interview with Licensed Employee E5 on May 30, 2025, at 9:33 a.m. revealed that Resident 223's Quarterly MDS dated [DATE], inaccurately reflected a significant weight loss for Resident 223. 28 Pa. Code 211.5(f) Clinical Records

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the facility's policy, clinical records, and staff interviews, it was determined the facility failed to timely and comprehensively assess a pressure ulcer wound resulting in actual harm to one resident (Resident 2) and failed to follow physician's wound treatment orders for three of the 11 residents reviewed (Residents 2, 62, and 225). Findings include: Review of the facility's policy titled Skin Integrity, dated April 1, 2022, revealed documentation and care interventions for skin integrity including assessment/observation to be completed within the first twenty-four hours of admission/quarterly/significant change in condition using admission Nursing Evaluation. Review of Resident 2's diagnosis list revealed diagnoses including Quadriplegia (paralysis of all four extremities), Epilepsy (seizures), protein calorie malnutrition, Bipolar Disorder (psychiatric disorder) and Major Depressive Disorder (mental disorder characterized by persistent and debilitating feelings of sadness, loss of interest in activities, and other symptoms that interfere with daily life). Review of Resident 2's care plan revealed Resident 2 had a goal of Activities of Daily Living (basic, routine tasks necessary for personal care and independence) performance deficit related to functional decline and Quadriplegia. Interventions included requiring assistance of two staff persons for repositioning and turning in bed. Further review of the care plan revealed Resident 2 was totally dependent on staff for toilet use, with an intervention to check and change every two hours. Further review of the care plan revealed potential for impairment to skin integrity related to fragile skin, immobility, and incontinence. Interventions included monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to MD (physician). Review of Resident 2's weekly skin check assessment dated [DATE], revealed no new skin issues. Review of Resident 2's weekly skin check assessment dated [DATE], revealed no new skin issues. Review of Resident 2's weekly skin check assessment dated [DATE], revealed no new skin issues. Review of Resident 2's progress notes dated February 17, 2025, revealed during care, this nurse was notified that the resident had a skin tear (type of traumatic wound caused by mechanical forces like friction, blunt force trauma, or falls, resulting in the separation of skin layers) on sacrum (large, triangular bone at the base of the spine) and an abrasion (superficial rub or wearing off of the skin, usually caused by a scrape or a brush burn) right posterior (back) thigh. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 2's second skin check assessment dated [DATE], revealed Stage 3 (serious wound that penetrates through the skin layers into the subcutaneous tissue, revealing the underlying fat) sacral/buttocks 5.0 x 10 x 2 cm (centimeters) moderate serosanguinous (type of wound drainage that contains both serous fluid [the clear, thin liquid part of blood] and blood cells) drainage, 40% slough (dead tissue that separates from the living tissue), 60% granulation tissue (fleshy, pink or red, moist tissue that forms on the surface of a wound as it heals) appears as a blister that popped. Review of Resident 2's clinical record failed to reveal documented evidence that Resident 2 had a blister on the sacrum. Interview with Licensed Employee E3 on May 29, 2025, at 11:00 a.m. revealed Resident 2 appeared to have had a blister on sacrum, however, no clinical documentation was provided to support a blister was present. This interview further revealed, Resident 2 experienced a delay in treatment by the wound consultant until March 6, 2025 as a result of the resident being out of bed or unavailable when the wound consultant was available. Interview with Director of Nursing on May 30, 2025, at 10:00 a.m. revealed Resident 2 had a history of a prior sacral wound and that a blister was present on the sacrum. No clinical documentation was provided to support either a prior sacral wound history or the presence of a blister on the sacrum. Review of Resident 2's initial wound consultation dated March 6, 2025, revealed Resident 2 had a significant past medical history of quadriplegia, mild protein-calorie malnutrition. Further review of same consultation revealed patient presents for initial evaluation of a new Stage 3 pressure ulcer of sacrum. Area has 20% slough (dead tissue within a wound, often appearing as a yellow, tan, or white fibrous material). Further review of the same wound consultation revealed Sacral wound is a Stage 3 pressure ulcer and has received a status of not healed. Initial wound encounter measurements are 3.5 cm length x 8 cm width x 0.1 cm depth with an area of 28 square centimeters. Assessment of exposed structures limited to the breakdown of skin. No tunneling (type of wound that extends deeper into the tissue than its surface, creating a narrow channel or tunnel-like passageway) has been noted. No sinus tract (type of wound characterized by a narrow channel or passageway that extends from the surface of the skin into deeper tissues) has been noted. No undermining (wound where the edges are not attached to the underlying tissue, creating a pocket or shelf beneath the skin at the wound's edge) has been noted. There is a light amount of sero-sanguineous drainage noted which has no odor. Wound bed has 80% granulation, 20% slough; no eschar (dead tissue) and no epithelialization (process of the epidermis regenerating over a wound surface, essentially covering the wound with new skin tissue) present. Interview with Director of Nursing on May 30, 2025, at 12:00 p.m. confirmed no clinical documentation was available to support that Resident 2 had a blister on the sacrum prior to the discovery of the Stage III pressure ulcer and that no treatments were in place to treat a blister. This interview also confirmed Resident 2's pressure ulcer was discovered at the level of Stage III. The facility failed to timely identify a pressure ulcer prior to the progression to a Stage III causing actual harm to Resident 2. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Clinical records review revealed Resident 62 was admitted to the facility on [DATE], with a diagnosis of Acute Respiratory Failure (life-threatening condition where the lungs are unable to adequately exchange gases [oxygen and carbon dioxide] in the blood, leading to insufficient oxygen delivery to the body and potentially harmful levels of carbon dioxide). Review of Resident 62's admission skin assessment failed to reveal a skin impairment to the sacrum and or the buttock area. Review of Resident 62's skin care plan developed on May 2, 2025, revealed: [Resident] has potential for impairment to skin integrity r/t (related to) muscle weakness. Stage 3 (Full thickness skin loss) left buttock. Review of Resident 62's physician's orders dated May 2, 2025, revealed an order to cleanse the wound with normal saline solution, pat dry, and cover with silicone border gauze every day shift every Tuesday, Thursday, and Saturday. Review of Resident 62's nursing skin/wound note dated May 8, 2025, at 11:29 a.m., revealed Skin assessment of buttocks. The resident states he/she had the wound for a long time. Stage 3 left buttock. 0.3 x 0.2 x 0.1 cm. Small serosanguinous (type of wound drainage that is a combination of blood and serum). 20% slough (non-viable yellow, tan, gray, green, or brown tissue; usually moist, can be soft, stringy, and mucinous in texture). 80% granulation. Clinical record review revealed Resident 62's Stage 3 left buttock/sacral pressure ulcer was not comprehensively assessed (size, condition) until May 8, 2025, six days after it was identified upon admission on [DATE]. Interview with the Director of Nursing conducted on May 30, 2025, at 10:00 a.m., confirmed Resident 62's identified on admission pressure ulcer was not comprehensively assessed until May 8, 2025. Clinical records review revealed Resident 225 was admitted to the facility on [DATE], with a Stage 4 (full-thickness skin and tissue loss) pressure ulcer to the sacrum (triangular bone just below the lumbar vertebrae) measuring 8.5 x 10 x 0.2 cm. with heavy serosanguinous drainage with 50% slough and 50% granulation. A wound treatment was ordered. Review of Resident 225's wound physician's consult report dated March 27, 2025, revealed a Stage 4 sacral wound, measuring 7.0 x 10 x 0.2 cm. with 40% slough. A wound care order to cleanse with wound cleanser, apply Hydrogel (water-rich dressing that maintains a moist wound environment, promoting healing and potentially reducing pain), and cover with bordered gauze (bandage with adhesive tape that holds the dressing in place) daily. Review of Resident 225's Treatment Administration Record (TAR) revealed the wound physician's treatment order for the sacrum initiated March 27, 2025 was not implemented until March 31, 2025, four days after it was ordered. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview with licensed nurse Employee E3 was conducted on May 29, 2025, at 1:00 p.m. Employee E3 reported that she/he does weekly rounds with the wound physician. Employee E3 reported, after the wound report was reviewed by the Interdisciplinary Team, she/he was responsible for entering it as an order on the resident's electronic medical records. Employee E3 reported the order was not implemented because it was not placed as an order until March 31, 2025, because he/she just did not get to it. The above information was conveyed to the Director of Nursing on May 30, 2025, at 10:00 a.m. 28 Pa. 211.10(c) Resident care policies Previously cited 6/7/24 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services Previously cited 6/7/24

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on a review of facility policy, clinical records, and staff interview, it was determined that the facility failed to ensure weights were monitored and a significant weight change was promptly addressed for three out of fifteen residents reviewed (Resident 36, 223 and 274). Findings include: A review of the facility's policy titled Weight Assessment and Intervention, revised February 15, 2022, revealed Any weight change of greater than or less than 5 pounds within 30 days will be retaken for confirmation. The dietician will also review monthly weights by the 10th of the month to follow individual weight trends. Negative trends will be assessed and addressed by Dietician whether or not the definition of Significant Weight change is met. If the weight loss meets the definition of Significant, the Dietician should discuss with the Interdisciplinary Team and make recommendations. Review of Resident 36's clinical record revealed diagnoses including depression and unspecified severe protein-calorie malnutrition (critical condition resulting from adequate intake of protein and calories). Review of Resident 36's clinical record revealed weights were obtained as follows: April 2, 2025 - 102.7 pounds, May 3, 2025- 94.4 and May 4, 2025 - 95.2 pounds, indicating a 7.30% weight loss. Review of Resident 36's clinical records and nutrition assessment failed to reveal evidence of significant weight loss being identified and intervention being put in place to address the weight loss. Review of Resident 223's Weight Summary revealed Resident 223 weighed 144 pounds on March 12, 2025. Further review of Resident 223's Weight Summary revealed Resident 223 weighed 134.2 pounds on March 13, 2025. Review of clinical documentation revealed that no re-weight was obtained until April 10, 2025, at which time Resident 223 weighed 142 pounds. Documentation from the Registered Dietitian revealed RD [registered dietitian] obtained reweight to refute recent weight change. CBW [current body weight] 142 pounds. No timely re-weight was obtained after the March 13, 2025, weight, resulting in an inaccurate MDS (minimum data set assessment - periodic assessment of resident needs) being submitted. Interview with Licensed Employee E6 on May 30, 2025, at 9:27 a.m. revealed that a reweight should have been obtained prior to the April 10, 2025, re-weight to obtain an accurate weight and complete an accurate MDS assessment. Review of Resident 274's clinical record revealed diagnoses' including epilepsy (brain condition that causes recurring seizure), chronic obstructive pulmonary disease (lung and airway disease that restricts your breathing) and unspecified severe protein-calorie malnutrition (critical condition resulting from adequate intake of protein and calories). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 274's clinical records revealed that weights were obtained as follows: April 4,2025 - 143 pounds, May 3, 2025- 127.2 and May 4, 2025 - 131 pounds indicating a 8.39% weight loss. Review of Resident 274's clinical records and nutrition assessment failed to reveal evidence of significant weight loss being identified and intervention being put in place to address the weight loss. Interview with Licensed Employee E6 on May 30 2025 at 11.20 a.m. confirmed the above 28 Pa. Code 211.5(f) Clinical Records

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of facility policy, observations, and interview with staff, it was determined that the facility failed to store food in accordance with professional standards for food service safety in the freezer area. Findings included: Review of facility policy, Food Storage Dating & Labeling, Revised December ninth, 2022, revealed that Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated Observations in the freezer on May 27th, 2025, at 10:00 AM revealed a bag of frozen burgers opened and undated. In additionally, there were frozen chicken patties opened and without a date. Interview on May 27th, 2025, during the kitchen tour with Employee E-4 confirmed all items should be labeled and dated. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 211.10(a) Resident care policies