

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395461	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Tucker House Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 Wallace Street Philadelphia, PA 19123	

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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>06525</p> <p>Based on clinical record review, policy and procedure review and interviews with staff, it was determined that the facility failed to assure an ongoing collaboration with the dialysis facility for the provision medications as ordered by the physician before and after hemodialysis treatment for one of one residents on renal dialysis. (Resident R1)</p> <p>Findings include:</p> <p>A review of the facility policy titled Administering Medications dated April 1, 2022 revealed that the licensed nurse was responsible for administering and documenting in the clinical record the administration of medications and treatments according to the orders, in required time frames, as set forth by the physician.</p> <p>A review of the policy titled Dialysis dated April 1, 2022 revealed that it was the facility's responsibility to ensure that the dialysis services were managed so that each resident attain or maintain their highest practicable physical, mental and psychosocial well-being. The policy indicated that it was the responsibility of the facility to ensure that the resident's needs related to dialysis treatment was met. The policy also indicated that it was the facility's responsibility to ensure effective communication and collaboration of the resident's care plan in order to implement the dialysis care among the nursing home and dialysis staff.</p> <p>Review of the facility's dialysis contract revealed that the facility contracted with an outside dialysis center to provide hemodialysis care and services, within professional standards of practice for the residents. According to the contract, the center and the facility were to provide ongoing communication and collaboration with the dialysis facility regarding the residents' care and services.</p> <p>Review of Resident R1's March 2023 physician's orders revealed an order for hemodialysis (a machine that filters wastes, salts and fluids from the blood when a person's kidneys are not working normally) care weekly on Monday, Wednesday and Friday, by the physician.</p> <p>Clinical record review revealed that Resident R1 was scheduled to leave the facility weekly at 5:00 a.m., on Monday, Wednesday and Friday and return to the facility at 12:00 noon each Monday, Wednesday and Friday after completing hemodialysis care.</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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Clinical record review revealed that the physician had ordered medications to be administered to Resident R1 before his departure for the dialysis center. The nursing staff were responsible for giving Resident R1 the medication Lispro (insulin) 10 units subcutaneously before meals for diabetes mellitus. The resident was scheduled morning doses on March 1, 2024, March 4, 2024, March 6, 2024, March 11, 2024. Review of the medication administration record revealed no evidence that the medication was administered according to the physician's orders.</p> <p>Clinical record review revealed that the physician had ordered medications to be administered to Resident R1 upon return from the dialysis center. The physician had ordered that Lispro (insulin) 10 units be administered subcutaneously at noon, upon return from the dialysis center. On March 1, 2024, March 6, 2024, March 8, 2024 and March 11, 2024 upon return from dialysis at noon the insulin, Lispro as ordered by the physician was not given to Resident R1.</p> <p>Clinical record review revealed that physician had ordered that Phos lo (calcium acetate phosphate binder) oral capsule 667 mg be administered three times a day at 8:00 a.m., 12:00 p.m., and 5:00 p.m., daily to Resident R1 for hyperkalemia. On March 1, 2024, March 4, 2024, March 6, 2024 March 8, 2024 and March 11, 2024 Resident R1 did not receive the medication Phos lo as ordered by the physician for administration at 8:00 a.m. Clinical record review revealed that Resident R1 was not administered the medication phos lo, as ordered by the physician at 12:00 p.m., on March 1, March 8, 2024 and March 11, 2024.</p> <p>Clinical record review revealed that Resident R1 was ordered apixaban a 5mg tablet one tablet every 12 hours for atrial fibrillation to be administered at 9: 00 a.m., and 9:00 p.m., daily. On March 1, 2024, March 4, 2024 March 8, 2024 and March 11, 2024 this resident did not receive the 9:00 a.m., doses as ordered by the physician.</p> <p>Clinical record review revealed that Resident R1 was ordered medication isosorbide mononitrate ER 60 mg one tablet one time a day for hypertension. On March 1, 2024, March 4, 2024, March 6, 2024 and March 11, 2024 Resident R1 did not receive the medication, isosorbide mononitrate ER as ordered by the physician.</p> <p>Interview with the director of nursing, Employee E2, at 2:00 p.m., on March 15, 2024 confirmed that Resident R1 who had a diagnosis of end stage kidney disease and was ordered hemodialysis treatments outside of the facility three days during the week was not receiving medications as ordered by the physician for the month of March, 2024.</p> <p>28 PA. Code 201.18(b)(1)(3) Management</p> <p>28 PA. Code 211.10(a)(b)(d) Resident care policies</p> <p>28 PA. Code 211.12(d)(1)(2)(3)(5) Nursing services</p> <p>28 PA. Code 211.5(f)(x)(ix)(viii)(vii) Medical records</p> <p>28 PA. Code 201.21(c) Use of outside resources</p>		