

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 11/15/2024
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277</p> <p>Based on review of facility policy, review of clinical records, observation, and staff interview it was determined that the facility failed to develop and implement a comprehensive care plan related to mobility, vision, and pressure ulcers for four of 35 residents reviewed (Residents R65, R1, and R102).</p> <p>Findings Include:</p> <p>Review of facility policy Baseline Care Plan, Comprehensive Care Plan and Ongoing Care Plan Updates dated April 1, 2022, revealed the facility will develop and implement a comprehensive person-centered care plan for each resident. The comprehensive care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.</p> <p>Review of Resident R65's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated August 21, 2024, revealed the resident was cognitively impaired and had diagnoses of hemiplegia (paralysis on one side of the body) affecting the left side and muscle weakness.</p> <p>Observations on November 12, 2024, at 10:30 a.m. revealed Resident R65's left hand was contracted. Resident R65 made a closed fist with the left hand due to contracture (permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen).</p> <p>Interview on November 12, 2024, at 10:32 a.m. with Registered Nurse, Employee E11, confirmed Resident R65's left hand was contracted, causing Resident R65 to make a closed fist with his hand.</p> <p>Further interview on November 12, 2024, at 10:32 a.m. with Registered Nurse, Employee E11, revealed Resident R65 was dependent on staff for feeding assistance due to limited mobility.</p> <p>Review of Resident R65's clinical record revealed no documented evidence a comprehensive care plan was developed and implemented to address Resident R65's left hand contracture. Review of Resident R65's comprehensive care plan revealed it did not include specific interventions to maintain or improve, or to prevent further decline, in the resident's range of motion and mobility.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R1's clinical record revealed the resident had an eye exam on September 6, 2024, and was diagnosed with glaucoma (damage to the optic nerve (the connection between your eyes and your brain that lets you see)), and cataract (cloudy area in the lens of your eye that can make your vision blurry, hazy, or less colorful).</p> <p>Review of Resident R1's care plan dated May 12, 2024, revealed that the care plan only addressed vision problems in the risk of fall.</p> <p>Interview on November 15, 2024, at 9:41 am with Regional Registered Nurse, Employee E3, revealed that vision impairment is only noted in the fall care plan and the care plan would be updated to address the new diagnosis of glaucoma.</p> <p>Review of Resident R102's clinical record revealed the resident was admitted [DATE] with a diagnoses that included chronic respiratory failure, muscle wasting and atrophy, and dysphagia (difficulty swallowing).</p> <p>Further review of Resident R102's clinical record revealed an order dated August 19, 2024 to apply heel protectors to bilateral heels daily and to remove to assess feet and care.</p> <p>Interview with Resident R102 on November 14, 2024 at 9:45 a.m. revealed Resident R102 only wears one heel protector at times due to preference or refuses both heel protectors.</p> <p>Review of Resident R102's care plan revealed the new intervention to apply heel protectors to Resident R102 daily or Resident R102's refusal to wear heel protectors at times was not included in Resident R102's care plan.</p> <p>Interview on November 14, 2024 at 10:00 a.m. with Licensed Nurse, Employee E8, confirmed Resident R102's care plan did not include the intervention to apply heel protectors daily or Resident R102's refusal to wear heel protectors at times.</p> <p>28 Pa. Code 211.10 (c) Resident care policies.</p> <p>28 Pa. Code 211.10 (d) Resident care policies.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>51165</p> <p>Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for two of five residents reviewed (Residents R85, R89).</p> <p>Findings include:</p> <p>Review of facility policy titled Care Plans (dated April 2022) indicated that the interdisciplinary team must review and update the care plan when there has been a change in the resident's condition.</p> <p>Clinical record review revealed Resident R85 was admitted to the facility August 3, 2023 with a diagnosis that included but not limited to diabetes mellitus (chronic disease that causes high blood sugar levels), anxiety disorder, and dementia.</p> <p>Review of Resident R85's clinical record revealed Resident R85 had a significant weight loss from June 2024 through November 2024.</p> <p>Further review of Resident R85's clinical record revealed an order, dated October 08, 2024, for two house shakes a day for weight loss.</p> <p>Review of Resident R85's care plan revealed interventions that included one house shake to be given daily. Resident R85's care plan did not include the updated order for two house shakes to be given daily.</p> <p>Further review of Resident R85's care plan revealed Residents R85's goal is to maintain weight stability within 3% of current weight, 115.8 lbs, through next review date. Resident R85's current weight is 107.6 lbs, which is greater than the 3% goal of 115.8 lbs.</p> <p>Resident R85's care plan was revised on November 12, 2024, but did not include an updated/revised goal to reflect Resident R85's current weight loss.</p> <p>Interview with Dietician, Employee E7, on November 14 at 12:00 p.m. confirmed Resident R85 is on two house shakes daily and has a current weight of 105.7 lbs.</p> <p>Clinical record review revealed Resident R89 was admitted to the facility December 12, 2023 with a diagnoses of thrombotic pulmonary embolism (when blood clot travels to an artery in the lung, blocking blood flow), muscle wasting and atrophy, and lack of coordination.</p> <p>Review of Resident R89's Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) dated October 14, 2024 revealed Resident R89's bed mobility and transfer required two or more persons physical assist.</p> <p>Review of Resident R89's care plan revealed one person physical assist for bed mobility and transfer.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Licensed nurse, Employee 8, on November 14 at 9:53 a.m. confirmed Resident R89 requires two persons assist when repositioning in bed and transferring Resident R89.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>43277</p> <p>Based on review of clinical record, observations, and staff interview, it was determined that the facility failed to provide nail care for a dependent resident for one of 30 residents reviewed (Resident R65).</p> <p>Findings Include:</p> <p>Review of Resident R65's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated August 21, 2024, revealed the resident was cognitively impaired and had diagnoses of hemiplegia (paralysis on one side of the body) affecting the left side and muscle weakness. Further review of the MDS revealed Resident R65 was dependent on staff for personal hygiene.</p> <p>Review of Resident R65's comprehensive care plan revised August 25, 2021, revealed the resident had an activities of daily living self-care performance deficit related to decreased mobility. Intervention revised on September 30, 2019, included to check nail length and trim and clean on bath day and as necessary.</p> <p>Review of Resident R65's nursing kardex (a documentation system that enables nurses to write, organize, and easily reference key patient information that shapes their nursing care plan) revealed the resident received a bed bath on November 14, 2024.</p> <p>Observations on November 12, 2024, at 10:30 a.m. revealed Resident R65's left hand was contracted. Resident R65 made a fist with the left hand due to contracture.</p> <p>Observations on November 15, 2024, at 9:15 a.m. with Licensed Nurse, Employee E10, revealed Resident R65's fingernails on bilateral hands were significantly long and required trimming.</p> <p>28 Pa. Code 211.12 (d)(5) Nursing services</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277</p> <p>Based on review of facility policy, review of clinical record, and staff interview, it was determined that the facility failed to evaluate and address the nutrition needs of each resident in a timely manner for two of four residents reviewed for nutrition (Resident R84 and R107).</p> <p>Findings Include:</p> <p>Review of facility policy Weight Assessment and Intervention dated February 15, 2022, revealed the nursing staff and the Registered Dietitian will cooperate to prevent, monitor, and intervene for undesirable weight loss for the residents. Further review of facility policy revealed if a weight loss is significant, the Registered Dietitian should discuss with the interdisciplinary team and make recommendations. Per the facility policy, significant weight change is defined as more or less than 5% within 30 days, and more or less than 10% within 6 months.</p> <p>Review of Resident R84's comprehensive Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated February 5, 2024, revealed the resident had moderate cognitive impairment and had diagnoses of adult failure to thrive (refers to a decline, often accompanied by weight loss, muscle wasting, fatigue, and decreased overall quality of life), muscle wasting, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life).</p> <p>Interview on November 12, 2024, at 10:45 a.m. with Resident R84 revealed the resident complained of being hungry and a reported history of weight loss.</p> <p>Review of Resident R84's clinical record revealed a comprehensive nutrition assessment dated [DATE], which indicated that the resident was at nutrition risk. Resident R84 was assessed based on a weight of 125.4 pounds and was deemed underweight per standards of professional practice. The nutrition assessment indicated that a gradual weight gain was desired and that the Registered Dietitian would reassess as needed.</p> <p>Review of Resident 84's weight history revealed a documented weight on February 12, 2024, of 128 pounds and a documented weight on February 17, 2024, of 117.8 pounds, which reflected a 7.9% significant weight loss in one week.</p> <p>Continued review of Resident R84's weight history revealed a re-weigh was obtained on February 20, 2024, confirming the weight loss with a documented weight of 118.3 pounds.</p> <p>Review of Resident R84's entire clinical record revealed no documented evidence the Registered Dietitian was made aware of the weight loss. Further review of Resident R84's clinical record revealed no documented evidence the Registered Dietitian promptly addressed Resident R84's significant weight loss and reviewed, and modified interventions consistent with the resident needs.</p> <p>Continued review of Resident R84's clinical record revealed the Registered Dietitian did not address Resident R84's significant weight loss from February 17, 2024, until a nutrition assessment on May 6, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R107's comprehensive MDS dated [DATE], revealed the resident was cognitively impaired and had diagnoses of alcohol dependence, cognitive communication deficit, and lack of coordination.</p> <p>Observations on November 12, 2024, at 10:18 a.m. revealed Resident R107 was wandering up and down the hallway. Resident R107 was observed to have a physically thin appearance.</p> <p>Interview on November 12, 2024, at 10:20 a.m. with Registered Nurse, Employee E11, confirmed Resident R107 is physically active most of the day wandering up and down the hallway.</p> <p>Review of Resident R107's nutrition assessment dated [DATE], identified Resident R107 to be at nutrition risk. Per the nutrition assessment, it can be difficult to have Resident R107 sit down for a full meal. Resident R107 frequently wanders near the nurse's station and would benefit from having finger foods/sandwiches to eat while walking around.</p> <p>Continued review of Resident R107's nutrition assessment dated [DATE], revealed the resident was assessed at a weight of 152.3 pounds and was noted with a gradual weight loss over time. The Registered Dietitian added snacks between meals as an intervention with the goal for weight maintenance.</p> <p>Review of Resident R107's weight history revealed a documented weight on February 1, 2024, at 152.3 pounds and a documented weight on March 14, 2024, at 144.4 pounds, which reflected a 5.19% significant weight loss in one month.</p> <p>Continued review of Resident R107's weight history revealed the resident's weight continued to trend down per a documented weight of 141.8 pounds on May 1, 2024.</p> <p>Review of Resident R107's entire clinical record revealed no documented evidence the Registered Dietitian was made aware of the weight loss. Further review of Resident R107's clinical record revealed no documented evidence the Registered Dietitian promptly addressed Resident R84's significant weight loss and reviewed, and modified interventions consistent with the resident needs.</p> <p>Continued review of Resident R107's clinical record revealed the Registered Dietitian did not address Resident R107's significant weight loss from March 14, 2024, until a nutrition assessment on May 15, 2024.</p> <p>28 Pa. Code 211.10 (c) Resident care policies</p> <p>28 Pa. Code 211.12 (d)(3) Nursing services</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>43277</p> <p>Based on review of facility policy, review of clinical record, and staff interview, it was determined that the facility failed to ensure that pain management was provided to residents consistent with standards of professional practice for one of one resident reviewed for pain (Resident R70).</p> <p>Findings Include:</p> <p>Review of facility policy Administering Pain Medication dated April 1, 2022, revealed the purpose of the policy was to provide guidelines for assessing the resident's level of pain prior to administering pain medications. Review of facility policy revealed staff should obtain the location and intensity of the pain. Staff should evaluate the effectiveness of non-pharmacological interventions and administer pain medications as ordered. Further review of facility policy revealed staff should document per facility protocol in the resident's electronic health record.</p> <p>Review of Resident R70's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated September 7, 2024, revealed the resident was cognitively impaired and had a diagnosis of myalgia (muscle pain) of head and neck.</p> <p>Review of Resident R70's physician order summary revealed an order dated March 24, 2022, to give two 325 milligram Tylenol tablets every six hours as needed for mild pain.</p> <p>Observations on November 12, 2024, at 10:24 a.m. revealed Resident R70 was tearful in the hallway requesting pain medication from Registered Nurse, Employee E11. Registered Nurse, Employee E11, reminded Resident R70 that Tylenol was already given and should begin to alleviate pain soon.</p> <p>Review of Resident R70's medication administration record revealed Registered Nurse, Employee E11, did not document the administration of the as needed pain medication on November 12, 2024.</p> <p>Review of Resident R70's clinical record revealed no documented evidence non-pharmacological interventions were implemented prior to administration of pain medications.</p> <p>Continued review of Resident R70's clinical record revealed no documented evidence that staff completed a pain assessment and obtained the location and intensity of the pain prior to medication administration. Further review of Resident R70's clinical record revealed no documented follow-up to evaluate the effectiveness of the pain medication administered.</p> <p>Interview on November 12, 2024, at 1:10 p.m. with Registered Nurse, Employee E11, confirmed Resident R70 was given pain medication in the morning of November 12, 2024, due to generalized pain.</p> <p>Interview on November 15, 2024, at 10:41 a.m. with Regional Registered Nurse, Employee E3, confirmed the nurse did not document the administration of the as needed Tylenol for Resident R70 on November 12, 2024. Further interview confirmed the nurse did not accurately document a pain assessment for Resident R70 as required.</p> <p>28 Pa. Code 211.9 (a)(1) Pharmacy services.</p> <p>(continued on next page)</p>		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12 (d)(5) Nursing services.

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46106</p> <p>Based on review of clinical records, staff and resident interviews, it was determined that the facility failed to identify the resident's possible triggers that may cause re-traumatization related to post-traumatic stress disorder (PTSD) for one of one resident sampled with a diagnosis of PTSD. (Resident R 81)</p> <p>Findings include:</p> <p>A review of the clinical record revealed that Resident R81 was admitted to the facility on [DATE], with diagnoses to include suicidal ideations, major depressive disorder, and (PTSD)</p> <p>Further review of the clinical record for Resident R81 revealed that the resident was sexually and physically abused by his father as a child.</p> <p>Resident R81's current care plan on August 29, 2024, revealed a care plan for PTSD. Further review of the care plan failed to identify possible triggers that may cause re-traumatization.</p> <p>Interview with the Director of Nursing, Employee E1, on October 18, 2024, at 11:00 a.m. confirmed that Resident R81's plan of care for PTSD did not identify the resident's possible triggers that may cause re-traumatization.</p> <p>Interviewed Regional nurse, Employee E3 on November 14, 2024, at 2:30 p.m. revealed that care plan did not identify possible triggers that may cause re traumatization.</p> <p>28 Pa. Code 211.12(c)(d)(3)(5) Nursing services</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>39343</p> <p>Based on observation, review of facility policy and procedure and interviews with staff, it was determined that the facility failed to maintain an effective infection control program related to hand hygiene during one of the six Medication Administration Reviews, and during peg tube dressing change for one of one resident review with a feeding tube</p> <p>Findings include:</p> <p>Review of facility policy title Hand Hygiene, and Enhanced Barrier Precautions (EBP), indicated that the staff will follow established infection control procedures such as hand washing, antiseptic technique, gloves, and isolation precautions for administration of medications, care, and treatments, as applicable.</p> <p>Observation conducted during medication administration to Resident R 85 on November 13, 2024, 9:11 a.m., with Licensed nurse, Employee E5, revealed that with bare hands Employee E5, touched the drawer of the medication cart, computer mouse, and medication-blister-pack; and without disinfecting her hands; the employee picked up medication tablet, Olanzapine Oral Tablet 10 milligram, and Klonopin Oral Tablet 0.5 MG, from the medication-blister-pack; and placed in the medicine- dispensing-cup. At the time of the finding, Employee E5 confirmed the same.</p> <p>Review of care plan for Resident R98, initiated on October 22, 2024, indicated that the resident was on Enhanced Barrier Precautions (EBP) related to Tube Feeding (EBP are a set of targeted gowns- and-glove-use- practices, designed to reduce the spread of Staphylococcus Aureus, a type of bacteria, and Multidrug-Resistant Organisms. EBP are used during high-contact-resident-care activities, and are indicated for residents with indwelling medical devices, such as: central lines, urinary catheters, feeding tubes, and tracheostomies).</p> <p>On November 13, 2024, 12:24 p.m., observed the peg-site-dressing-change administered to Resident R98, by a Licensed Nurse, Employee E6 revealed that Employee E6, did not wear the Personal Protective Equipment (PPE), which was essential to act in accordance with the Enhanced Barrier Precautions. Employee E6, also did not remove the soiled gloves, and did not put-on clean gloves, before placing the new dressing around the peg site. At the time of the finding, employee E6 confirmed the same.</p> <p>28 Pa Code 211.10(c) Resident care policies</p> <p>28 Pa Code 211.12 (d)(1)(5) Nursing services</p>