

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2024
NAME OF PROVIDER OR SUPPLIER Accelerate Skilled Nursingandrehabilitation Phila		STREET ADDRESS, CITY, STATE, ZIP CODE 1526 Lombard Street Philadelphia, PA 19146	

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 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347</p> <p>Based on review of facility documentation, clinical record review, resident and staff interviews, it was determined that the facility failed to ensure that intravenous antibiotic therapy was ordered for a resident was admitted for antibiotic therapy for one of eight residents. (Resident R1)</p> <p>Findings include:</p> <p>Review of resident R1's clinical record revealed, this resident was admitted to the facility on [DATE] with a diagnosis of diabetes (a chronic metabolic disease characterized by elevated levels of blood glucose (blood sugar)which leads to serious damage to the heart, blood vessels, eyes , kidneys , and nerves), liver cirrhosis (chronic liver damage which can lead to liver failure) a liver transplant, COPD (Chronic Obstructive Pulmonary Disease - a chronic inflammatory lung disease that causes obstructed airflow from the lungs), recently hospitalized for pneumonia (a lung infection that inflames air sacs in one or both lungs, which may fill with fluid) resulting in sepsis (the body's overactive and extreme response to an infection, sepsis is a life threatening medical emergency).</p> <p>Review of the hospital discharge instructions revealed that the instruction for skilled nursing facility summarized Resident R1's medical history, diagnosis's and that this resident is undergoing IV (intravenous) antibiotic therapy.</p> <p>Further review of the hospital discharge instructions revealed that Resident R1 needed a PICC line (A peripherally inserted central catheter (PICC), is a long, thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart. Very rarely, the (line placed to receive antibiotics for an extended period). Resident R1 required placement in a special skilled nursing facility to facilitate getting these antibiotics via IV.</p> <p>Continued review of the hospital document revealed skilled nursing facility instructions that stated resident was receive iv antibiotics as well as summary of care that stated resident will be discharged to a skilled nursing facility to receive IV antibiotics.</p> <p>Review of the discharged medication list, did not include antibiotic therapy. Review of hospital discharge notice dated January 19, 2023, revealed that it was signed by the facility's physician assistant.</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 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Resident R1's family member on January 30, 2024, at 9:00 a.m. approximately revealed that he had asked the nurse for the antibiotic, stating she had not received it since entering the facility. He stated Resident 1 needed this medication, and it was not being given to her. He was told the facility did not have it and was waiting for the order. He then requested that Resident R1 be sent to the emergency room . Resident R1 was readmitted into the hospital on January 23, 2023, after not being able to receive antibiotics at rehabilitation.</p> <p>Interview with Resident R1 on January 30, 2024, approximately at 10:00 a.m. revealed that the resident was fully aware that she required iv antibiotic upon entering the facility from the hospital discharge on January 19, 2024. Resident R1 did not receive her third dose after the transfer to the facility and requested the IV antibiotic form the nursing staff. The resident stated that she was supposed to receive three doses daily and still needed her third dose of the day she was admitted to the facility. Resident R1 was told that the facility did not have the IV antibiotic. Resident R1 stated that for the next two days (Saturday, January 20, and Sunday January 21, 2023) she had told the nursing staff that she needed her antibiotic but was told it was on order.</p> <p>Review of hospital discharge summary on January 26, 2023, revealed that there was no clinical evidence of recurrent infection, however, remains high for failure given approximately 2-3 days of missed antibiotics.</p> <p>Interview with Licensed nurse, Employee E3 via telephone, on January 30, 2023 at 11:25 a.m. revealed that she was on duty January 21,2023 , when the family member of Resident R1 requested the antibiotic. Employee E3 confirmed that an order for antibiotic therapy should have been verified and began to set up the IV.</p> <p>Interview with Nursing Home Administrator, Employee E1 and Director of Nursing, Employee E2 on January 30, 2023, at 1:40 p.m. revealed that they were aware of the medication error. Employee E2 produced documentation of the hospital discharge summary that did not include the IV antibiotic. Employee E1 believed that this was a miscommunication of the hospital.</p> <p>There was no documented evidence that the facility contacted the hospital to review the resident's medication list since there was no order for an IV antibiotic medication for a resident who was admitted with a PICC line to receive antibiotic therapy.</p> <p>201.14 (a). Responsibility of licensee</p> <p>201.18. (b)(1) Management</p> <p>211.9. (f)(2) Pharmacy services</p> <p>211.12. (d)(5)Nursing services</p>		