STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395485	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accelerate Skilled Nursingandrehabilitation Phila	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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 38947 Based on observations, staff and resident interviews, and review of facility documentation, it was determined that the facility failed to ensure a comfortable air temperature levels for 4 out of 4 residents reviewed receiving dialysis treatment (Resident R5,R6, R7an R8). Findings include: Review of the Home Hemodialysis Coordination Agreement, between the hemodialysis center that is located inside the facility indicated that it is the facility's responsibility to ensure that the dialysis center located inside the facility is compliant with all applicable, laws, rules and regulations, including licensure and certification requirements Continued review of the Home Hemodialysis Coordination Agreement, also indicated that the facility will provide and safe and sanitary environment for dialysis treatments, provide utilities to the dialysis company, including electricity, gas and HVAC (heating, ventilation, and air conditioning), and also be responsible for the maintenance of its own equipment that is not provided by the dialysis company. The Centers for Medicare and Medicaid Services (CMS) requires that dialysis facilities to maintain a comfortable temperature for the majority of the patients, with the community standard ranges anywhere between 72 and 75 degrees Fahrenheit Fahrenheit. Review of information provided to the state survey agency indicated that the dialysis center (located in the basement of the facility) was experiencing high temperatures due to repairs that are needed to the facility's cooling system. Review of August 2024 physician orders indicated that the following residents were receiving hemodialysis treatment onsite at the facility (Resident R5, R6, R7, and R8). During an observation in the dialysis center on August 22, 2024 at 3:30 p.m. with the Director of Maintenance (Employee E4), the dialysis room was entered and felt warm. Three temporary cooling units were present and were running. The temperatures taken by the Director of Maintenance in various parts of the dialysis room were 79.3, 80.1, and 80.3-degrees Fahrenheit. (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

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 08/23/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on August 22, 2024 at 4:45 p.m. with Resident R5, the resident was asked if the temperatures in the dialysis center were comfortable for him during his treatments. Resident R5 stated, It is hot down there. Those things they got (the portable coolers) are not running at the temperature that they should be. During an observation in the facility's onsite dialysis center on August 23, 2024, at 12:00 p.m. the room temperature felt warm and Resident R5, R6, R7 and R8 were observed receiving their dialysis treatment for the day. Three temporary cooling units were present and running. The dialysis employee center nurse (DE1) used a temperature gun recorded the current temperature at 12:00 p.m. as being 83 degrees Fahrenheit. A temperature recorded at 12:30 p.m. in the dialysis center by the dialysis employee center nurse was 85.6 degrees. Dialysis staff, Employee E1 reported that the air conditioning unit broke in the basement back in June 2024 and the dialysis center was provided with the cooling units that do not maintain the dialysis center at an appropriate temperature of 71-75 degrees Fahrenheit. The dialysis nurse reported that having the room set at the above referenced temperature range also aides in ensuring that solutions such as saline and sodium bicarbonate, used during dialysis treatment, are maintained at safe temperatures in order to be effective. During the above referenced interview, the dialysis nurse described the dialysis center as being very hot. The dialysis technician (DE3) also described it as very hot. and reported that there were times in June 2024 that they (DE1 and DE3) took the temperatures throughout the day and it would get as high as 97 degrees (Fahrenheit) in here. Interview with the Director of Maintenance (Employee E4) on August 23, 2024 at 12:22 p.m. reported that he became aware of a concern with the cooling system around June 5, 2024, from the dialysis center employees. Employee E3 reported that cooling units were brought into the dialysis center to utilize until the cooling unit that controls the basement could be repaired or replaced. Employee E3 reported that quotes for a company to service the cooling system were obtained and it was determined by the chosen servicing company that the parts that were needed for the cooling system were not available, and had to be manufactured. An estimated date for the servicing company to service the cooling unit is September 9, 2024. Review of temperature logs of the dialysis center taken by Employee E3 during the various times during the morning hours (7:45 a.m. through 9:15 a.m.) of July 18, 2024, through August 22, 2024 documented temperatures in the dialysis center that ranged from 80-83 degrees Fahrenheit. On June 17, a temperature of 85 degrees Fahrenheit was documented as being taken at 2:00 p.m. in the dialysis center. Continued interview with Employee E3 confirmed that the monitoring of temperatures in the dialysis unit started on July 17, 2024, and that there was no monitoring of temperatures taken in the dialysis center during the month of June 2024 when the cooling unit became in operable. 28 Pa. Code 207.2(a) Administrators responsibility

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38947 Based on staff interviews, review of facility documentation, and the state survey reporting system, it was determined that the facility failed to ensure that allegations of abuse and neglect were reported to the state survey agency for 4 out of 4 residents reviewed (Resident R1, R2, R3 and R4). Findings include: Review of the facility policy, Abuse Prohibition, with a revision date of October 2, 2022 indicated that immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the Administrator or designee will report allegations to the appropriate state and local authority(s) involving neglect, exploitation or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of patient property, no later than 2 hours after the allegation is made, if the event results in serious bodily injury, or within 24 hours if the event does not result in serious bodily injury. Continued review of the policy indicated that the facility would initiate an investigation within 24 hours of an allegation of abuse, protect patients from further harm during an investigation, and report findings of all completed investigations within 5 working days to the state survey agency. Review of the resident's August 2024 physician orders indicated that Resident R1 was admitted into the facility on [DATE] with diagnosis that included the following: osteoarthritis (a degenerative joint disease resulting in pain and stiffness); polyneuropathy (a condition in which an individual's peripheral nerves are damaged such as the face, arms and legs); hypertension (high blood pressure) and diarrhea. Review of the resident Grievance/Concern book revealed a grievance submitted on behalf of Resident R1 on August 14, 2024, stating that he had been sitting in feces all day and no one would help him get cleaned. The resident reported in his grievance that the morning nurse aides told him that he asked too late and had to wait for the next shift. Review of the August 2024 physician orders for Resident R2 indicated that she was admitted into the facility on [DATE] with diagnosis that included the following: hypokalemia (low blood potassium levels); glaucoma (a group of eye diseases that damages the optic making it difficult to see clearly); atrial fibrillation (a condition of the heart that is characterized by an irregular and often rapid heartbeat); hypertension (high blood pressure); diabetes (a condition that affects your blood sugar levels and can cause serious complications) and difficulty in walking. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident Grievance/Concern book revealed a grievance submitted by the daughter of Resident R2 dated July 22, 2024. The grievance stated that the resident did not receive care on July 20, 2024 and July 21, 2024, and that she had the same clothes on that she had on Friday. The grievance also stated that the resident's teeth were not brushed. Continued review of the grievance indicated a concern with a named nurse aide on Friday who allegedly threw the resident's wet pats on the dresser, and left the resident on a wet sheet. The grievance also alleged that the named nurse aide was confrontational and said that she was working by herself. The grievance also documented a concern with a 2nd named nurse aide who allegedly told Resident R2 to urinate in her diaper, and instructed that resident not to take it off because she (the 2nd named nurse aide) was working by herself. The grievance also alleged that a 3rd named nursing staff employee does nothing at night. Review of the August 2024 physician orders for Resident R3 indicated that the resident was admitted into the facility on [DATE] with diagnosis that included the following: asthma (a lung disorder lung disorder that causes shortness of breath, wheezing and coughing); kidney failure (a condition when one or both kidneys no longer work on their own); heart failure (a condition in which the heart muscles can't pump blood as well as they should); respiratory failure (a life threatening condition that affects a persons breathing and oxygen levels), and morbid obesity. Review of the resident Grievance/Concern book revealed a grievance submitted on behalf of the resident dated July 28, 2024. The grievence indicated a concern that included allegations related to an incident with the nurse aide at 2:00 a.m. on Saturday night. The allegation reported in the grievence was that the nurse aide assisted the resident to the commode, appeared disgusted with her, and tossed the resident's feet on the bed did not straighten her up, and walked out. Review of the August 2024 physician orders for Resident R4 indicated that the resident was admitted into the facility on [DATE] with diagnosis that included the following: cerebral infarction (a stroke); diabetes (a group of disease that affect how the body uses blood sugar); dementia (a group of symptoms affecting an individual's memory, thinking and social abilities), and chronic obstructive pulmonary disease (COPD-a chronic lung disease that makes breathing difficult). Review of the resident Grievance/Concern book revealed a grievance submitted on behalf of the resident dated August 14, 2024 which alleged that the aides for all shifts are not helping the resident use the toilet, and are telling her to go in her brief. The grievance form also stated that as a result of the above, the resident had to take herself to the bathroom because no one would help. Review of the reporting system for the facility's state survey agency did not show evidence that the state survey agency was notified, and the resutlts of any investigation was reported regarding the referenced allegations. During a discussion with the Director of Nurse (DON) and the Regional Nurse on August 23, 2024, at 11:15 a.m. regarding the above referenced allegations, it was discussed that the above referenced concerns were not reported to the state survey agency to rule about abuse/neglect, as required. 28 Pa. Code 51.3 (f) Notification 28 Pa. Code 51.3 (g)(6) Notification 28 Pa. Code 211.12 (d)(5) Nursing Services

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NAME OF PROVIDER OR SUPPLIER Accelerate Skilled Nursingandrehabilitation Phila		STREET ADDRESS, CITY, STATE, ZIP CODE 1526 Lombard Street Philadelphia, PA 19146	

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38947 Based on staff interviews and review of facility documentation, it was determined that the facility failed to conduct a complete and thorough investigation regarding allegations of abuse/neglect for 4 out of 4 residents reviewed (Resident R1, R2, R3 and R4). Findings include: Review of the facility policy, Abuse Prohibition, with a revision date of October 2, 2022 indicated that immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the Administrator or designee will report allegations to the appropriate state and local authority(s) involving neglect, exploitation or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of patient property no later than 2 hours after the allegation is made if the event results in serious bodily injury or within 24 hours if the event does not result in serious bodily injury. Continued review of the policy indicated that the facility would initiate an investigation within 24 hours of an allegation of abuse, protect patients from further harm during an investigation, and report findings of all completed investigations within 5 working days to the State Survey Agency. The policy also indicated that the investigation would be thoroughly documented, and that documentation of witnessed interviews would be included. Review of the resident's August 2024 physician orders indicated that Resident R1 was admitted into the facility on [DATE] with diagnoses of osteoarthritis (a degenerative joint disease resulting in pain and stiffness); polyneuropathy (a condition in which an individual's peripheral nerves are damaged such as the face, arms and legs); hypertension (high blood pressure) and diarrhea. Review of the resident Grievance/Concern book revealed a grievance submitted on behalf of Resident R1 on August 14, 2024, stating that he had been sitting in feces all day and no one would help him get cleaned. The resident reported in his grievance that the morning nurse aides told him that he asked too late and had to wait for the next shift. A typed statement dated August 14, 2024 and signed by the Director of Nursing (DON) indicated that she was notified that the resident needed assistance with incontinence care, went up to his floor and made sure that staff provided it. No additional information was provided regarding the investigation related to the allegations reported on Resident R1's behalf Review of the August 2024 physician orders for Resident R2 indicated that she was admitted into the facility on [DATE] with diagnoses of hypokalemia (low blood potassium levels); glaucoma (a group of eye diseases that damages the optic making it difficult to see clearly); atrial fibrillation (a condition of the heart that is characterized by an irregular and often rapid heartbeat); hypertension (high blood pressure); diabetes (a condition that affects your blood sugar levels and can cause serious complications) and difficulty in walking. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident Grievance/Concern book revealed a grievance submitted by the daughter of Resident R2 dated July 22, 2024. The grievance stated that the resident did not receive care on July 20, 2024 and July 21, 2024, and that she had the same clothes on that she had on Friday. The grievance also stated that the resident's teeth were not brushed. Continued review of the grievance indicated a concern with a named nurse aide on Friday who allegedly threw the resident's wet pads on the dresser, and left the resident on a wet sheet. The grievance also alleged that the named nurse aide was confrontational and said that she was working by herself. The grievance also documented a concern with a 2nd named nurse aide who allegedly told Resident R2 to urinate in her diaper, and instructed that resident not to take it off because she (the 2nd named nurse aide) was working by herself. The grievance also alleged that a 3rd named nursing staff employee does nothing at night. A typed, undated statement with the first and last name of the 2nd named aide was obtained and it was noted that she was assigned to Resident R2 on July 21, 2024. The nurse aide reported that outside of asking the Resident R2 and her roommate about their morning care, the best time to assist them with it, giving them breakfast, lunch, water, and checking on them throughout the day, the 2nd named nurse aide reported that she did not have any other interactions with them. She also reported that a co-worker answered the call bell for Resident R2 and went in to assist Resident R2 with either using the bathroom or assisting the resident with changing herself. No additional information was provided regarding the investigation related to the allegations reported on Resident R2's behalf. Review of the August 2024 physician orders for Resident R3 indicated that the resident was admitted into the facility on [DATE] with diagnoses of asthma (a lung disorder lung disorder that causes shortness of breath, wheezing and coughing); kidney failure (a condition when one or both kidneys no longer work on their own); heart failure (a condition in which the heart muscles can't pump blood as well as they should); respiratory failure (a life threatening condition that affects a persons breathing and oxygen levels), and morbid obesity. Review of the resident Grievance/Concern book revealed a grievance submitted on behalf of the resident dated July 28, 2024. The grievence indicated a concern that included allegations related to an incident with the nurse aide at 2:00 a.m. on Saturday night. The allegation reported in the grievence was that the nurse aide assisted the resident to the commode, appeared disgusted with her, and tossed the resident's feet on the bed did not straighten her up, and walked out. There was also a concern related to missing medication. The grievence noted that the resident's missing medication was adminstered. No additional information was provided regarding the investigation related to the other allegations reported on Resident R3's. Review of the August 2024 physician orders for Resident R4 indicated that the resident was admitted into the facility on [DATE] with diagnoses of cerebral infarction (a stroke); diabetes (a group of disease that affect how the body uses blood sugar); dementia (a group of symptoms affecting an individual's memory, thinking and social abilities), and chronic obstructive pulmonary disease (COPD-a chronic lung disease that makes breathing difficult). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident Grievance/Concern book revealed a grievance submitted on behalf of the resident dated August 14, 2024 which alleged that the aides for all shifts are not helping the resident use the toilet, and are telling her to go in her brief. The grievance form also stated that as a result of the above, the resident had to take herself to the bathroom because no one would help. No additional information was provided regarding the investigation related to the other allegations reported on Resident R3's. Continued review of the Grievance/Concerns for Resident R1, R2, R3 and R4 regarding allegations of not receiving appropriate care and services by facility staff did not include any evidence provided by the facility that a complete and thorough investigation was conducted to ensure that abuse/neglect was ruled out. During a discussion with the Director of Nurse (DON) and the Regional Nurse on August 23, 2024, at 11:15 a. m. regarding the above referenced allegations, it was discussed that there was no evidence that a complete and through investigation was completed by the facility to rule out abuse/neglect. 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 201.18(b)(1)(3) Management

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38947 Based on staff interviews, and review of clinical records, it was determined that the facility failed to ensure that residents received care and services for dialysis treatment that was consistent with professional standards of practice for dialysis care for 2 out of 4 residents reviewed for dialysis treatment (Resident R6 and R8). Findings include: Review of the facility policy, Dialysis: Hemodialysis (HD)-Communication and Documentation with a revision date of June 15, 2022 indicated that the facility staff will communicate with the certified dialysis facility regarding the ongoing assessment of the patient's condition by monitoring for complications before and after the patient receives the treatments. The policy also indicated that upon return to the facility, a licensed nurse will review the dialysis center communication form related to the resident treatment, evaluate and observe the patient, and complete the post-hemodialysis treatment section on the Hemodiaysis Comunication Record. Review of the August 2024 orders indicated that the resident was admitted into the facility on [DATE], with diagnosis that included hypertension (high blood pressure); heart failure (a condition where the heart muscle can't pump blood as well as it should); diabetes (a group of disease that affect how the body uses blood sugar) and dependence on renal dialysis. Review of nursing notes from March 2024 through August 2024 indicated that the resident was receiving dialysis treatments on Mondays, Wednesdays, and Fridays. Review of the August 2024 physician orders for Resident R6 did not show evidence that the resident had a physician's order for dialysis treatment. Continued review of the resident's clinical record also did not include a person-centered plan of care for dialysis treatment to ensure that goals and interventions related to this care area are developed and implemented to meet the resident's needs. Review of the clinical records for Resident R6 did not include any evidence that the resident's condition was monitored post dialysis treatment for complications (e.g. blood pressure, temperature weight), in addition to assessing, observing and also documenting the care of the resident dialysis access site (the site that is utilized to reach the individual's blood during dialysis treatment) post dialysis treatment. During an interview with the dialysis center Regional Operations Manager (DE2) on August 26, 2024, at 1:14 p.m. she confirmed that Resident R6 had been receiving onsite dialysis treatment at the facility since March 27, 2024. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the August 2024 physician orders for Resident R8 indicted that the resident was admitted into the facility on [DATE] with diagnosis of human Immunodeficiency virus (HIV); hypotension (low blood pressure); dysphagia (difficulty swallowing); malnutrition (lack of sufficient nutrients in the body; end state renal disease (the gradual loss of kidney function that reaches an advanced state), and dependence on renal dialysis. Review of nursing notes from August7, 2024 through August 23, 2024 indicated that the resident was receiving dialysis treatments on Mondays, Wednesdays, and Fridays. Review of the August 2024 physician orders for Resident R6 did not show evidence that the resident had a physician's order for dialysis treatment. Continued review of the resident's clinical record also did not include a person-centered plan of care for dialysis treatment to ensure that goals and interventions related to this care area are developed and implemented to meet the residents needs. Review of the clinical records for Resident R6 did not include any evidence that the resident's condition was monitored post dialysis treatment for complications (e.g. blood pressure, temperature weight), in addition to assessing, observing, and also documenting the care of the resident dialysis access site (the site that is utilized to reach the individual's blood during dialysis treatment) post dialysis treatment. During an interview with the dialysis center Regional Operations Manager (DE2) on August 26, 2024, at 1:14 p.m. she confirmed that Resident R8 had been receiving onsite dialysis treatment at the facility since August 9, 2024. During an interview with the Director of Nursing (DON) and the Regional Nurse on August 23, 2024, at 6:00 p.m. it was discussed that the clinical record for Resident R6 and R8 did not show evidence of physician orders for dialysis treatment, a care plan for dialysis treatment, or any evidence that Residents R6 and R8 are being monitored and assessed by nursing staff post dialysis treatment. 28 Pa Code 211.12(d)(1)(5) Nursing services 28 Pa Code 211.12(d)(3) Nursing services