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	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graduate Post Acute	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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471 Based on review of facility policies and documentation, clinical record review and interviews with staff, it was determined the facility failed to provide adequate supervision to one of ten residents reviewed (Resident R1), who did not have a leave of absence (LOA) order. This failure resulted in Resident R1 exiting the third floor via elevator and walking out the front entrance of the facility. Resident R1 was located two hours after the resident exited the facility approximately 1.2 miles away from the facility in a busy [NAME] area. This failure placed the resident at high risk for injury and was identified as an Immediate Jeopardy past non-compliance. (Resident R1) Findings include: Review of facility policy, Wandering and Elopements dated March 2019, revealed The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Further review revealed that If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. 2. If an employee observes a resident leaving the premises, he/she should: a. attempt to prevent the resident from leaving in a courteous manner; b. get help from other staff members in the immediate vicinity, if necessary; and c. instruct another staff member to inform the charge nurse or director of nursing services that a resident is attempting to leave or has left the premises. Review of facility policy, Resident Leaves of Absence dated March 2022, revealed that Residents may safely leave the premises for a planned leave of absence (LOA). The physician will be made aware of the resident, or resident's representative's, request for the resident to go on LOA and will provide an order to allow the resident to go on LOA, if deemed safe and appropriate. The resident will notify the nurse prior to leaving the facility and will sign-out. It is requested that an estimated time of return is provided. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395485	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graduate Post Acute	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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident R1's clinical records revealed that the resident was admitted on [DATE], with past medical history of repeated falls, difficulty walking, fracture of pelvic bone, and cognitive communication deficit. Review of an admission MDS (Minimum Data Set- assessment of resident care needs) dated January 22, 2025 revealed that the resident had a BIMS (Brief Interview for Mental Status) score of 10 which indicated that the resident's cognitive status was moderately impaired. Review of care plan for Resident R1 dated January 16, 2025, revealed that the resident was at risk for fall related to the history of fall with injury. Continued review of the care plan revealed that the resident required one person staff assistance for ambulation. Review of physician order for Resident R 1 from January 2025 through April 24, 2025, revealed no documented evidence that the resident had a physician order for leave of absence. Review of a psychotherapy progress note dated April 9, 2025, revealed that the resident had a diagnosis of major depressive disorder and general anxiety disorder. Resident was seen because resident reported frustration and low motivation. Review of facility investigation dated April 13, 2025, revealed that the nursing assistant assigned to the resident alerted the nurse that earlier in the shift, Resident R1 told her that the resident needed to walk, but the resident did not elaborate further. The nursing assistant at that time thought the resident was talking about walking on the unit. Later, in the shift when the nursing assistant went to the resident's room, she stated that the resident was not there. At this time the nursing assistant alerted the charge nurse, and a Code Yellow (Emergency protocol for Elopement) was announced. Further review of the investigation revealed that it was estimated that Resident R1 left the faciity on [DATE], at 3:53 p.m. through the front door. Resident R1 was appropriately dressed for the day and was ambulating with the roller walker. It was revealed that the resident arrived at a friend's apartment, the friend (who is also Resident R1 's emergency contact) was not home, however a neighbor who also knew Resident R1 contacted the friend who in turn notified the facility, The resident's friend confirmed that Resident R1 had arrived at her apartment to visit with her, but she was not home. Upon notification a nurse from the facility went to the apartment and picked up the resident and returned her to the facility at 6:30 p.m. Resident R1 stated that (she/he) was going to visit her friends in the community where (she/he) lived prior to (her/his) admission to the facility. Review of a statement from Receptionist, Employee E9, dated April 13, 2025, revealed that a group of family members came downstairs off the elevator and right behind was an individual, well dressed with a purse in hand. The receptionist indicated that she was unaware that the individual was a resident of the building due to the individual being well dressed. Employee E9 stated she was think that the individual was just visiting a resident that lived in the facility. The individual was walking slow to the door however the person stopped at the carpet because the walker got caught up in the carpet. When employee looked up the individual was able to fix (herself/himself), after the individual walked out of the building. (continued on next page)

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	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graduate Post Acute	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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a statement from Nurse Aide, Employee E10, dated April 13, 2025, revealed that she checked on resident when she came for her shift. Employee went to Resident R1's room and said hello to the resident. Resident was sitting on the bed dressed up. Resident told the employee (she/he) needed to walk. Employee told (her/him) to sit as the dinner will be served. Later dinner was served and the resident was not in her room. Review of a statement from Registered Nurse Supervisor, Employee E9, dated April 13, 2025, revealed that at approximately 5:15 p.m., the assigned aide brought to her attention that Resident R1 was not in (her/his) room. The aide stated earlier resident mentioned that (she/he) needed to walk but she was not in (her/his) room. Employee E10 went out and bought the resident back to the facility. Review of nursing note for Resident R1 revealed a nurse's note, dated April 13, 2025, at 6 :30 p.m. which indicated that the assigned nurse aide informed the writer that [Resident R1] who is alert and oriented x 2-3 (people, place and time) mentioned earlier during her rounds that (she/he) needs to walk but (she/he) returned at a later time and noted resident was not back in (her/his) room. Resident exited the center through the front desk. The employee went out and brought resident back to the center. Interview with Resident R1 on April 24, 2025, at 10:30 a.m. revealed that the resident was not able answer the name of the facility (she/he) was in and the day of the week as well as the date. But resident stated the facility would not let (her/him) go outside so (she/he) sneaked out the facility for few hours and sneaked back in without facility staff noticed. Resident did not remember if staff bought (her/him) back. Interview with Receptionist, Employee E12 on April 24, 2025, at 10:43 a.m. revealed that when resident's go out of the facility they must sign out. There were only three residents that were allowed to go out, however Resident R1 was not one of them. Any other resident when they exit the receptionist must stop them and let the nursing know that the resident was trying to leave. A facility surveillance camera review was conducted with Employee E13, Regional Staff on April 24, 2025, at 10:43 a.m. revealed that on April 13, 2025, at 3:54 p.m. three visitors walked towards the front entrance, Resident R1 was walking approximately 6 feet behind the visitors. It was revealed that the Employee E9, who was the receptionist at the time, was doing personal shopping on the computer, she was scrolling the shopping website looking at the computer. Employee did not look at the resident when the resident first appeared in the camera. Employee opened the front door by pressing the button at the front desk. Then door closed before Resident R1 exited. Employee E9 looked up saw the resident and pressed the button to open the front door. Resident R1 was observed slowly walking out with a walker. It was also showed that the three family members did not wear a visitor badge nor sign out at the front which was the facility protocol for anyone exiting the facility. Employee E9 did not appear to ask the visitors or the resident to sign out or return the visitor badge. Outside facility security camera showed that there were numerous cars passing by the facility, which was approximately 10 to 15 feet from the front entrance. Resident R1 walked with walker through the sidewalk and later disappeared from the camera view. (continued on next page)

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	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graduate Post Acute	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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Registered Nurse Supervisor, Employee E11, on April 24, 2025, at 12.18 p.m. stated after the resident was missing from the facility, she called resident's personal number and one of the staff from a senior living picked up the phone. Employee stated resident walked to the place. Employee drove her car to the place and picked up the resident ad brought the resident back to the facility. Registered Nurse Supervisor, Employee E11 also stated resident did not have an order for LOA and was not allowed to leave the facility premises unaccompanied. Interview with Receptionist, Employee E9, on April 24, 2025, at 12:40 p.m. stated she was covering the front desk for another employee who called out on April 13, 2025. Employee E9 stated she saw resident walking towards the front with a walker. Resident R1's walker caught up on the carpet, resident fixed it and walked out. Employee E9 stated resident was well dressed and she did not know that it was a resident, otherwise she would have stopped the resident. Employee E9 also stated every visitor must sign in and out at the front entrance and wear a visitor badge while visiting and return the badge when leaving. Employee E9 confirmed that the visitation protocol was not followed. Review of an internet map data revealed that the resident was located 1.2 miles away from the facility in a busy [NAME] area. There were busy intersections, and multilane traffic through the route to the location. Interview with Regional [NAME] President of Operations, Employee E14, on April 24, 2025, at 12.40 p.m. confirmed that Resident R1 did not have a physician order for LOA. Employee E14 confirmed that the resident should not have been allowed to leave the facility without proper supervision or physician order. Employee E14 also confirmed that Employee E9 had a clear view of the resident and still allowed the resident to leave without intervening. Employee E14 stated Employee E9 was not familiar with the resident thought it was a visitor. Employee E14 also confirmed that the facility did not follow the visitation protocol which would have helped distinguish between residents and visitors. Interview with Employee E14, Employee E1, Nursing Home Administrator and Employee E2, Director of Nursing on April 24, 2025, at 12.40 p.m. confirmed that the facility non-compliance with LOA and visitation protocol placed Resident R1 at risk for serious injury. Based on the above findings, an Immediate Jeopardy to the safety of the resident was identified for failure to provide adequate supervision of Resident R1 who did not have a leave of absence (LOA) order. This resulted in Resident R1 exiting the third floor via elevator and walked out of the front entrance of the facility while the receptionist, who was distracted by computer use (personal shopping), opened the front entrance door. Resident R1 was located two hours later after the resident exited the facility approximately 1.2 miles away from the facility in a busy [NAME] area. This failure placed the resident at high risk for injury. An Immediate Jeopardy template (a document which included information necessary to establish each of the key components of immediate jeopardy) was provided to the Nursing Home Administrator (NHA) on April 24, 2025, at 4:36 p.m. On April 15, 2025, the facility initiated a plan of correction to address the failure of ensuring that a resident was adequately supervised to prevent elopement. The facility plan of correction included the following: (continued on next page)

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	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graduate Post Acute	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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Resident left the Center to take a walk. The resident had walked to her previous address and was visiting (her/his) neighbors. The Center staff spoke with (her/his) friend, and (she/he) was assisted back to the Center. Upon return, RN Supervisor assessed, and no injuries were noted. Completed 4/13/2025 2. The Center completed a headcount of all residents and compared it to the midnight census to ensure all residents were accounted for and resting comfortably. Completed 4/13/2025 3. Immediate Actions/Education -The Nursing Administration held huddles on all floors with staff on duty to discuss the current residents which go on frequent LOAs as well as the signs and symptoms that may indicate the risk for leaving the Center without staff notification. No variances were noted, and no current residents were identified as an elopement risk. Completed 4/13/2025 -Shift RN Supervisor provided immediate education to receptionist on duty. Completed 4/13/2025. -RN Supervisors were educated on the completion of headcount of all residents compared to midnight census and the immediate reporting of any discrepancy to the Director of Nursing/designee. Completed 4/15/2025. Staff were educated on signs and symptoms that may indicate a risk of elopement. 91% completed 4/15/2025. The remainder was completed prior to the start of the next shift. 100% completion on 4/16/2025. Reception/security staff were educated on the process of each visitor receiving a badge that must be returned prior to door being opened and visitor leaving the premise. 91% completed 4/15/2025. The remainder was completed prior to the start of the next shift. 100% completion on 4/16/2025. Staff educated on elopement/missing person policy and procedure including code yellow announcement to notify staff in Center, search both on the premises and the surrounding areas, notification processes including local police department. 91% completed 4/15/2025. The remainder was completed prior to the start of the next shift. 100% completed on 4/16/2025. Staff educated on elopement drills including how often and expected response. 91% completed 4/15/2025. The remainder was completed prior to the start of the next shift. 100% completion on 4/16/2025. All the training above will be added to our general orientation schedule for all new future employees. Completed 4/15/2025. Residents with a current unsupervised LOA order were re-educated on the LOA policy/agreement and understood the sign out process with both the nursing staff on the unit Ongoing Compliance will be monitored by: Auditing census compared to headcount every 4 HRS (hours) for 3 days then every shift for 14 days then daily. All variances will be reported to the QAPI (Quality Assurance Improvement Program) Committee monthly. (continued on next page)

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	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graduate Post Acute	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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Random audit of five visitors to ensure compliance with the visitor pass system two times daily for 14 days then daily for two months. All variances will be reported to the QAPI Committee monthly. Daily audit of LOA log to ensure reception/security staff are checking for clearance to leave the Center. The audit will be completed daily for three weeks with all variances reported during the clinical meeting. The QAPI Committee will make recommendations to ensure continued compliance. Upon sustained compliance, the QAPI Committee will recommend the reduction or resolution of the audits. and the reception/security staff. Completed 4/15/2025. A review was conducted of staff education, resident elopement/wandering evaluations, facility visitation protocols, and LOA process. Interviews with facility staff were conducted on April 24, 2025, and April 25, 2025. Facility staff provided extensive feedback and understanding of the facility's Elopement policy, LOA policy and visitation process. Facility LOA and visitation process was verified through observations. Review of facility documentation revealed that the corrective action plan was immediately initiated on April 15, 2025. Following the verification of the immediate action plan the Nursing Home Administrator was notified that the Immediate Jeopardy was lifted on April 25, 2022, at 2:34 p.m. and identified as past non-compliance. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services

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	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graduate Post Acute	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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471 Based on review of job's descriptions, review of facility documentation and interviews with staff, it was determined that the Nursing Home Administrator and Director of Nursing failed to effectively manage the facility to ensure that adequate supervisor was provided to one of 10 residents reviewed (Resident R1). This failure resulted in Resident R1 exiting the third floor via elevator and walking out the front entrance of the facility. Resident R1 was located two hours after the resident exited the facility approximately 1.2 miles away from the facility in a busy [NAME] area. This failure placed the resident at high risk for injury and was identified as an Immediate Jeopardy of past non-compliance. (Resident R1) Findings include: Review of the job description of the Nursing Home Administrator (NHA) revealed that, the primary purpose of the job position is to direct the day-day-day functions of the Center in accordance with current feferral, state, and local standards, guidelines and regualtions that govern nursing Centers to assure that the highest degree of quality of care can be provided to the residents at all times. As Administrator, you are delegated the administrative authority, responsibility and accountability necessary for carrying out your assigned duties. Review of the job description of the Director of Nursing (DON) revealed that, the primary purpose of the job description is to plan, organize, develop and direct the overall operation of our Nursing Service Department in accordance with current federal, state, and local standards, guidelines and regulations that govern the Center, and as may be directed by Administrator and the Medical Director, to ensure that the highest degrees of quality care is maintained at all times. Review of Resident R1's clinical records revealed that the resident was admitted on [DATE], with past medical history of repeated falls, difficulty walking, fracture of pelvic bone, and cognitive communication deficit. Review of care plan for Resident R1 dated January 16, 2025, revealed that the resident was at risk for fall related to the history of fall with injury. Continued review of the care plan revealed that the resident required one person staff assistance for ambulation. Review of physician order for Resident R1 from January 2025 through April 24, 2025, revealed no documented evidence that the resident had a physician order for leave of absence. (continued on next page)

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	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graduate Post Acute	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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility investigation dated April 13, 2025, revealed that the nursing assistant assigned to the resident alerted the nurse that earlier in the shift, Resident R1 told her that the resident needed to walk, but the resident did not elaborate further. The nursing assistant at that time thought the resident was talking about walking on the unit. Later, in the shift when the nursing assistant went to the resident's room, she stated that the resident was not there. At this time the nursing assistant alerted the charge nurse, and a Code Yellow (Emergency protocol for Elopement) was announced. Further review of the investigation revealed that it was estimated that Resident R1 left the faciity on [DATE], at 3:53 p.m. through the front door. Resident R1 was appropriately dressed for the day and was ambulating with the roller walker. It was revealed that the resident arrived at a friend's apartment, the friend (who is also Resident R1 's emergency contact) was not home, however a neighbor who also knew Resident R1 contacted the friend who in turn notified the facility, The resident's friend confirmed that Resident R1 had arrived at her apartment to visit with her, but she was not home. Upon notification a nurse from the facility went to the apartment and picked up the resident and returned her to the facility at 6:30 p.m. Resident R1 stated that (she/he) was going to visit her friends in the community where (she/he) lived prior to (her/his) admission to the facility. Review of a statement from Receptionist, Employee E9, dated April 13, 2025, revealed that a group of family members came downstairs off the elevator and right behind was an individual, well dressed with a purse in hand. The receptionist indicated that she was unaware that the individual was a resident of the building due to the individual being well dressed. Employee E9 stated she was think that the individual was just visiting a resident that lived in the facility. The individual was walking slow to the door however the person stopped at the carpet because the walker got caught up in the carpet. When employee looked up the individual was able to fix (herself/himself), after the individual walked out of the building. Review of a statement from Registered Nurse Supervisor, Employee E9, dated April 13, 2025, revealed that at approximately 5:15 p.m., the assigned aide brought to her attention that Resident R1 was not in (her/his) room. The aide stated earlier resident mentioned that (she/he) needed to walk but she was not in (her/his) room. Employee E10 went out and bought the resident back to the facility. A facility surveillance camera review was conducted with Employee E13, Regional Staff on April 24, 2025, at 10:43 a.m. revealed that on April 13, 2025, at 3:54 p.m. three visitors walked towards the front entrance, Resident R1 was walking approximately 6 feet behind the visitors. It was revealed that the Employee E9, who was the receptionist at the time, was doing personal shopping on the computer, she was scrolling the shopping website looking at the computer. Employee did not look at the resident when the resident first appeared in the camera. Employee opened the front door by pressing the button at the front desk. Then door closed before Resident R1 exited. Employee E9 looked up saw the resident and pressed the button to open the front door. Resident R1 was observed slowly walking out with a walker. It was also showed that the three family members did not wear a visitor badge nor sign out at the front which was the facility protocol for anyone exiting the facility. Employee E9 did not appear to ask the visitors or the resident to sign out or return the visitor badge. Interview with Registered Nurse Supervisor, Employee E11, on April 24, 2025, at 12.18 p.m. stated after the resident was missing from the facility, she called resident's personal number and one of the staff from a senior living picked up the phone. Employee stated resident walked to the place. Employee drove her car to the place and picked up the resident ad brought the resident back to the facility. Registered Nurse Supervisor, Employee E11 also stated resident did not have an order for LOA and was not allowed to leave the facility premises unaccompanied. (continued on next page)

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	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graduate Post Acute	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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an internet map data revealed that the resident was located 1.2 miles away from the facility in a busy [NAME] area. There were busy intersections, and multilane traffic through the route to the location. Interview with Regional [NAME] President of Operations, Employee E14, on April 24, 2025, at 12.40 p.m. confirmed that Resident R1 did not have a physician order for LOA. Employee E14 confirmed that the resident should not have been allowed to leave the facility without proper supervision or physician order. Employee E14 also confirmed that Employee E9 had a clear view of the resident and still allowed the resident to leave without intervening. Employee E14 stated Employee E9 was not familiar with the resident thought it was a visitor. Employee E14 also confirmed that the facility did not follow the visitation protocol which would have helped distinguish between residents and visitors. Interview with Employee E14, Employee E1, Nursing Home Administrator and Employee E2, Director of Nursing on April 24, 2025, at 12.40 p.m. confirmed that the facility non-compliance with LOA and visitation protocol placed Resident R1 at risk for serious injury. Based on the deficiencies identified in this report, the Nursing Home Administrator and Director of Nursing failed to fulfill essential duties and responsibilities of their position to ensure that the Federal and State guidelines and Regulations were followed, contributing to the Immediate Jeopardy situation. Pa Code 201.14 (a)Responsibility of Licensee Pa. Code 201.18 (a)Management