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	04/13/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interviews with staff, review of grievances, and review of facility policy, it was determined that the facility did not ensure that prompt efforts were made to resolve residents' grievances related to missing items for 2 of 3 residents interviewed (Residents R7 and R8).Findings include: A Review of facility policy titled, Personal Property dated 2001, revealed under bullet 11. The facility promptly investigates any complains of misappropriation or mistreatment of resident property. A review of Resident R8's grievance dated March 18, 2026, revealed that the resident reported missing personal care items that went missing during a night shift. The facility met with the family on March 18, 2026, to take pictures of the missing items. The family requested replacement of Johnson's Baby Lotion (pink), Aveeno Skin Relief (small bottle), and Dove antiperspirant. The grievance form listed grievance as resolved on March 26, 2026. On April 13, 2026, at 11:45 a.m., an interview with the Administrator, Employee E1, confirmed that the items needed for replacement were ordered that day. An invoice was provided showing that the items were ordered on April 13, 2026. The Administrator also confirmed that the facility was not able to locate an inventory sheet for Resident R8. A review of Resident R7's grievance dated March 17, 2026, revealed that the resident's representative reported, I'm reaching out regarding an ongoing concern about my father's personal belongings. Over time, we have brought him at least eight pairs of pants and approximately fifteen shirts. Unfortunately, we have noticed that items have continually gone missing each week. The grievance form listed the grievance as resolved on March 23, 2026. A review of Resident R7's inventory sheet dated January 7, 2026, revealed that the resident had 4 shirts, 4 undershirts, 2 pajama pants, and 5 sweatpants. A second inventory sheet dated March 19, 2026, indicated 2 shirts and 3 sweatpants. An email dated April 8, 2026, from a family member of Resident R7 provided a detailed list of missing items, of which only two items were located. On April 13, 2026, at 11:45 a.m., an interview with the Administrator, Employee E1, confirmed that the grievance for Resident R7 has not yet been resolved, as the family only located a few items and still needs to speak with the night shift staff before reimbursement of items to the resident. 28 Pa. Code 201.29(a) Resident rights

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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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on closed clinical record review, and staff interview, it was determined that the facility failed to ensure that enteral feeding supplies were provided and available to be obtained at the time of discharged for one of two closed records reviewed. (Resident CL1)Findings include: A review of the closed clinical record of Resident CL1 revealed admission date of March 4, 2026, and discharge date of March 20, 2026, with diagnosis of cerebral infarction due to occlusion or stenosis of small artery (stroke), adult failure to thrive, dysphagia (difficulty swallowing), and moderate protein calorie malnutrition. An interview with the facility Registered Dietitian, Employee E4, on April 13, 2026, at 11:53 a.m., confirmed that Resident CL1 was receiving enteral feeds per the physician order dated March 13, 2026, administered six times daily at a rate of 165 mL (total 990 mL every 4 hours), providing 1,485 kcal and 73 grams of protein. The Registered Dietician, Employee E4 also indicated that Resident CL1 was consuming oral intake during the day and during the night receiving eternal feedings. A discharge progress notes from the Social Worker, Employee E5, who was not available for interview, documented on March 16, 2026, that social worker made aware that resident and family requested early discharge. Family stated they had everything in place for resident to go home and would like to work on discharge for Friday 3/20/26. A subsequent progress note, dated March 21, 2026, stated, social worker made aware that supplies needed for bolus feeding and/or gravity feeding were not provided. Social worker notes resident's son was trained on both, and SW called [Home Health Agency] to make them aware of feeding and supplies. SW obtained supplies to assist . until home health arrived on Monday. Family . arrived to obtain the supplies. A review of the discharge summary indicated that the Assistant Director of Nursing, Employee E6, was the individual who discharged the resident and signed off on the discharge documentation. The discharge documentation only indicated that a walker was needed and that it was ordered per the discharge summary. An interview with the Director of Nursing, Employee E2, on April 13, 2026, at approximately 11:35 a.m., confirmed that a Hoyer lift (mechanical lift) and sling were ordered on March 20, 2026, this items were not documented in the resident's clinical record or discharge summary. An interview was conducted on April 13, 2026, at approximately 2:55 p.m. with the Director of Nursing, Employee E2, and the Regional Nurse, Employee E7, during which it was difficult to obtain complete documentation regarding the ordering of enteral feeds post-discharge. On the same date at 3:20 p.m., the Director of Nursing, Employee E2, and the Regional Nurse, Employee E7, provided an invoice in Resident CL1's name showing that a hydraulic patient lift and commode were ordered and delivered on March 20, 2026. The records further showed that on March 23, 2026, irrigation kits, bolus supplies, and enteral nutritional formula were ordered and then canceled. A third invoice dated March 31, 2026, showed that enteral nutritional formula was again ordered and subsequently canceled. The facility was unable to provide an explanation for the multiple orders or the reasons for the cancellations. On April 13, 2026, at 3:33 p.m., an interview was conducted with the Assistant Director of Nursing, Employee E6, who signed off on the discharge summary on March 20, 2026. Employee E6 revealed that Resident CL1 was receiving specialized enteral feedings. The home health agency that accepted to provide in-home services did not have the specific brand and was unable to provide the supply to Resident CL1. Employee E6 stated that when the family called the facility on March 21, 2026, reporting that they did not have supplies, the facility provided a packet to the family post-discharge. When questioned about who was responsible for ensuring that Resident CL1 had the correct enteral feeds and appropriate brand, it was reported to be the social worker, who was not available for interview. However, per the discharge summary, it was the responsibility of the nursing staff who discharged Resident CL1. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, and staff interview, it was determined that the facility failed to maintain accurate records for one of two closed records reviewed (Resident CL2).Findings include: A review of clinical closed record for Resident CL2 revealed an admission date on January 13, 2026 with diagnosis of Intestinal obstruction, unspecified as to partial versus complete obstruction (blockage of the intestines with unclear severity), colostomy (Surgical opening of the colon to the abdominal wall), malfunction, ileostomy (surgical opening of the small intestine to the abdominal wall) kidney failure. Resident CL2's clinical record review showed that the resident was hospitalized on [DATE], and March 30, 2026. A review of the SNF/NF to Hospital Transfer Form revealed that an inaccurate form was completed with conflicting dates. The form documented the Date of Transfer to the Hospital as March 4, 2026, at 9:06 a.m., and indicated that the family was notified on March 4, 2026; however, vital signs documented on the form were dated March 30, 2026, and the form was signed on March 30, 2026. An interview with the Registered Dietitian, Employee E4, on April 13, 2026, at 11:53 a.m. confirmed that Resident CL2 was on a heart-healthy, full liquid diet. The documentation of the amount consumed by Resident CL2 was tracked by nursing assistant staff under the amount eaten at meal task. The amount eaten at meal task form was missing documented percentages for breakfast and lunch on March 18, 21, 22, 23, 25, and 27, 2026. On April 13, 2026, at 2:45 p.m., an interview with the Director of Nursing, Employee E2, confirmed that the Transfer to the Hospital form did not reflect accurate information for March 30, 2026, and that the amount eaten at meal task form was not completed for breakfast and lunch on March 18, 21, 22, 23, 25, and 27, 2026. 28 Pa. Code 211.5(f)(iv) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services