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	06/29/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, review of clinical records, review of facility documentation, and interviews with residents and staff, it was determined that the facility failed to protect one resident from verbal abuse for one of 10 residents reviewed (Resident R1). Findings include: Review of facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021, revealed that Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Review of the clinical record for Resident R1 revealed that the resident was admitted to the facility on [DATE], and has diagnoses of quadriplegia (paralysis that affects all a person's limbs and body from the neck down), cervical spinal fusion (a surgical procedure that permanently connects two or more vertebrae in the neck to alleviate pain and stabilize the spine). Review of Resident R1's MDS (minimum data set - a comprehensive resident assessment) revealed that the resident was totally dependent for all care (helper does all of the effort. Resident does none of the effort to complete the activity). Review of facility documentation submitted to the State Survey Agency revealed that on May 22, 2026, Resident R1 reported having a verbal dispute with one of the aides in regard to washing his/her face. On May 22, 2026, at 1:00 p.m. Resident R1 reached out to administration and filed a report of verbal abuse against Nurse Aide, Employee E10. Administration and social services spoke to Resident R1 who reported nurse aide, Employee E10, made threats to him/her and also made derogatory comments regarding Resident R1's family. The eyewitness to the altercation (identified as nurse aide, Employee E9) confirmed a verbal altercation between nurse aide, Employee E10, and Resident R1. Review of facility documentation revealed a witness statement dated May 22, 2026, from nurse aide, Employee E9, who reported that he/she came into Resident R1's room to provide care for the roommate, Resident R11. When entering the room, nurse aide, Employee E10, who was taking care of Resident R1, asked nurse aide, Employee E9, to relieve him/her so nurse aide, Employee E10, could take a break. Nurse aide, Employee E9, agreed to relieve nurse aide, Employee E10, for a break. Per the witness statement, Resident R1 asked nurse aide, Employee E10, where he/she was going, and said you can't go. Subsequently, Nurse aide, Employee E10, came back into Resident R1's and went back and forth arguing with Resident R1. It turned into Employee E10 yelling, f**** you p****, that's why you laying in the f****** bed and cant move, wearing a f****** diaper and can't do s***! Call your f****** wife, she is a weirdo. Resident R1 said to get out of his room. Employee E10 said, f*** your mother!. Per the witness statement dated May 22, 2026, by nurse aide, Employee E9, Resident R1 did go back and forth with nurse aide, Employee E10. Nurse aide, Employee E9, stated that he/she attempted to remove nurse aide, Employee E10, from the room but the argument happened so quickly and ended abruptly that he/she could not intervene quickly enough. Review facility documentation revealed a statement dated May 22, 2026, by nurse aide, Employee E10, that revealed that on May 22, 2026, he/she entered Resident R1's room and the resident was sleeping. When Resident R1 woke up he/she asked to be changed and nurse aide, Employee E10, (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	suggested he/she should wash/dress the resident, to which Resident R1 agreed. Nurse aide, Employee E10, went and got a basin, water, wash cloth and soap. Nurse aide, Employee E10, subsequently gave Resident R1 a rag to wash his/her face, to which the resident became upset that he/she couldn't do it and said nurse aide, Employee E10, wouldn't assist. Nurse aide, Employee E10, continued to change Resident R1 and cleaned him/her up after breakfast. Continued review of statement dated May 22, 2026, by nurse aide, Employee E10, revealed when attempting to leave Resident R1's room for a break, after being relieved by nurse aide, Employee E9, Resident R1 questioned where nurse aide, Employee E10, was going and became upset. Nurse aide, Employee E10, reports Resident R1 then began calling the employee vulgar names. Nurse aide, Employee E10, reported it to the unit manager and switched to a different assignment. Review of statement dated May 22, 2026, by Resident R11, confirmed that Resident R1 and Employee E10 were arguing. Resident R11 reported It was really bad on both parts. I don't want to get involved. Interview with the Nursing Home Administrator (NHA), Employee E1, and the Director of Nursing, Employee E2, on June 29, 2026, at 2:25 p.m. confirmed that the eyewitness statements from R1's roommate and Employee E9 corroborated each other that Employee E10 was arguing and using foul language toward Resident R1 in his room on May 22, 2026, and that this is verbal abuse. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 201.29(c) Resident rights 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(c) Nursing services