

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 11/22/2024
NAME OF PROVIDER OR SUPPLIER Graduate Post Acute		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 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>46993</p> <p>Based on review of facility provided documentation and interview with staff, it was determined that facility did not ensure to provide Notice Of Medicare Non-Coverage (NOMNC) to one out of three residents reviewed (Resident R20)</p> <p>Findings include:</p> <p>Review of facility provided documentation 'Medicare A Patients Cut from Skilled Care with Benefits Days Remaining,' revealed that Resident R20 was Medicare to Medicaid pending effective August 19, 2024.</p> <p>Facility unable to provide NOMNC for Resident R20 upon multiple requests during survey from November 20, 2024 through November 22, 2024; finding confirmed with facility's Social Services, Employee E11.</p> <p>28 Pa Code 201.29(f) Resident Rights</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347</p> <p>Based on review of clinical records, review of facility policy, facility documentation and resident and staff interviews, it was determined that the facility failed to ensure that residents were free from misappropriation and exploitation of property related to authorized use of resident's funds for two of two residents reviewed. (Resident R1 and Resident R22).</p> <p>Findings include:</p> <p>Review of facility policy titled Abuse Prohibition last revised October 24, 2022, revealed that the facility prohibits abuse, common mistreatment, common neglect, misappropriation of resident property, and exploitation for all patients. The center will implement an abuse prohibition program through the following: screening potential hires, training of employees, prevention of occurrences, identification of possible incidents or allegations which need investigation, investigation of incident and allegations, protection of patients during investigation and reporting of incidents investigations. Further review of this policy defined types of abuse which include Exploitation is defined as the act or process of taking advantage of a patient for personal gain through the use of manipulation, intimidation, threats, or coercion. Misappropriation of patient property is the is defined as the deliberate misplacement exploitation or wrongful temporary or permanent use of a patient's belongings or money without patient's consent, and mistreatment is defined as an inappropriate treatment or exploitation of a patient. Further review of this policy revealed training and reporting obligations will be provided to all employees through orientation code of conduct training, and minimum of annually will include the abuse prohibition policy, appropriate interventions to deal with aggressive reactions of patients, how staff should report their knowledge related to allegations without fear, how to recognize signs of burnout frustration and stress, Effective communication skills with patients, what constitutes abuse neglect and misappropriation of patient property. Actions to prevent abuse neglect exploitation and mistreatment injuries of unknown source and misappropriation of property will include providing patients families and staff with information identifying correcting and interviewing in situations in which abuse neglect and misappropriation the property is more likely to occur and evaluating whether the patient has the capacity to consent. The facility will take appropriate corrective actions.</p> <p>Review of facility Employee handbook included a welcoming program/orientation which will focus on the code of conduct, the company, the processes, policies, and procedures amongst other things.</p> <p>Included in this manual regarding safety and abuse, revealed that all employees are responsible for the safety and protection of the patients and residents in their care. Patients have the right to be free from abuse, neglect misappropriation of resident property, and exploitation. This includes, but not limited to freedom from corporal punishment, involuntary seclusion, and any type of physical or chemical restraint not required to treat the president's medical systems. The orientation continues to define all types of abuse include misappropriation of resident property.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility report submitted to the State Agency dated September 17, 2024, reported by the Director of Nursing, Employee E2 revealed that two separate staff members reported that nurse aide, Employee E16 was utilizing resident's EBT (electronic benefits transfer, government benefits such as food assistance) and debit cards to purchase outside food items at their request. Nurse aide, Employee E16 was purchasing items for herself using the patient's money and government benefits. At the time of the interview Resident R1 and Resident R22 admitted to giving their EBT card and debit card in order for her to purchase outside food and giving permission to her to purchase items for herself. The facility concluded that nurse aide, Employee E16 was made aware of the allegation and misappropriation of property, and it was grounds for immediate dismissal. Nurse aide, Employee E16 was terminated of her position at the facility.</p> <p>Review of facility documented investigation revealed that Resident R1 and Resident R2 were assessed as cognitively intact and admitted having given their debit and EBT cards to Employee E16 to purchase outside food for them as well as for herself. During interview nurse aide, Employee E16 stated she was unaware her action were in the category of misappropriation of property. The facility concluded that the allegation of misappropriation of property was found substantiated.</p> <p>Review of Resident R1's quarterly MDS (Minimum data set assessment of resident care needs) for Resident R1 dated August 5, 2024, revealed that the resident was admitted to the facility on [DATE], and had a BIMS (Brief Interview for Mental Status) score of 12, indicating that Resident R1 had moderate cognitive impairment.</p> <p>Interview with Resident R1 on November 20, 2024, at 1:50 p.m. revealed that the resident remembered telling nurse aide, Employee E16 that Employee E16 could get something for herself. Resident R1 did not remember if Nurse aide, Employee 16 asked him, or the resident volunteered, nor does this resident remember exactly how many times he gave the card to the Employee E16.</p> <p>Review of Resident R22's quarterly MDS dated [DATE], revealed that Resident R 22 was admitted into the facility March 13, 2024, with diagnoses of cerebrovascular accident (stroke), and Aphagia (a language disorder caused by brain damage that impairs the ability to communicate). Resident R22 was assessed as possessing unclear speech, can usually understand but may miss some intent of the message. Resident R22 BIMS score of 14, indicating that this resident cognition is intact.</p> <p>Interview with Resident R22 on November 20, 2024, at 2:10 p.m. revealed that this resident told Employee E16 that she could buy some food for herself. Resident R22 believe this only occurred two or three times. He does not know how much money the employee spent.</p> <p>Review of Nurse aide, Employee 16's personnel file revealed a signed documentation dated June 24, 2204 of receiving education on understanding of the facility's abuse policy. This education included definition of exploitation.</p> <p>Interview with Director of Nursing Employee E2 on November 22, 2024, at 10:55 a.m. revealed that the residents involved admitted to giving consent for Employee E16 to purchase food for herself. Employee E2 stated that is unknown how long the employee was doing this, or how much money she had spent on herself.</p> <p>28 Pa code 201.14 (a)(b) Responsibility of Licensee</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa code 201.18(b)(1)(3) Management</p> <p>28 Pa code 210.29 (a) Resident rights</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347</p> <p>Based on review of facility policy review of clinical records and staff interview it was determined that the facility failed to conduct and complete a thorough investigation to rule out misappropriation of resident funds for two of two resident records reviewed. (Resident R 1, and Resident R 22)</p> <p>Findings include:</p> <p>Review of facility policy titled Abuse Prohibition last revised October 24th, 2022, revealed that the facility prohibits abuse, common mistreatment, common neglect, misappropriation of resident property, and exploitation for all patients. The center will implement an abuse prohibition program through the following: screening potential hires, training of employees, prevention of occurrences, identification of possible incidents or allegations which need investigation, investigation of incident and allegations, protection of patients during investigation and reporting of incidents investigations. Further review of this policy defined types of abuse which include Exploitation is defined as the act or process of taking advantage of a patient for personal gain through the use of manipulation, intimidation, threats, or coercion. Misappropriation of patient property is the is defined as the deliberate misplacement exploitation or wrongful temporary or permanent use of a patient's belongings or money without patient's consent, and mistreatment is defined as an inappropriate treatment or exploitation of a patient. Further review of this policy revealed training and reporting obligations will be provided to all employees through orientation code of conduct training, and minimum of annually will include the abuse prohibition policy, appropriate interventions to deal with aggressive reactions of patients, how staff should report their knowledge related to allegations without fear, how to recognize signs of burnout frustration and stress, Effective communication skills with patients, what constitutes abuse neglect and misappropriation of patient property. Actions to prevent abuse neglect exploitation and mistreatment injuries of unknown source and misappropriation of property will include providing patients families and staff with information identifying correcting and interviewing in situations in which abuse neglect and misappropriation the property is more likely to occur and evaluating whether the patient has the capacity to consent. The facility will take appropriate corrective actions.</p> <p>Review of employee signed documentation of received education dated June 24, 2024 revealed that this employee has been educated and documented understanding of the facility abuse policy. This education included definition of exploitation is defined as the act or process of taking advantage of a patient for personal gain through the use of manipulation intimidation threats or coercion. The definition of misappropriation of a property is defined as a deliberate misplacement exploitation or wrongful temporary or permanent use of a of a patient's belongings or money without the patient's consent mistreatment is defined as the inappropriate treatment or exploitation of a patient.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility report submitted to the State Agency dated September 17, 2024, reported by the Director of Nursing, Employee E2 revealed that two separate staff members reported that nurse aide, Employee E16 was utilizing resident's EBT (electronic benefits transfer, government benefits such as food assistance) and debit cards to purchase outside food items at their request. Nurse aide, Employee E16 was purchasing items for herself using the patient's money and government benefits. At the time of the interview Resident R1 and Resident R22 admitted to giving their EBT card and debit card in order for her to purchase outside food and giving permission to her to purchase items for herself. The facility concluded that nurse aide, Employee E16 was made aware of the allegation and misappropriation of property, and it was grounds for immediate dismissal. Nurse aide, Employee E16 was terminated of her position at the facility.</p> <p>Review of facility documented investigation of the above event included a PB22 (a report form for investigation of alleged abuse, neglect ,misappropriation of property which included a description of the incident written by director of nursing employee E 2, stating the event occurred at the facility on September 17, 2024. The investigation was initiated at 11:00 a.m. and completed September 19, 2024 at 04:45 p.m. The investigation concluded that the two victims involved voluntarily gave Employee E16 funds to purchase. The description of incidents revealed that two employees reported that Employee E16 was utilizing resident's debit and EBT card for the residents and for herself. Finding of the investigation was that employee was unaware her actions was ground for termination was a violation.</p> <p>Review of facility documented investigation revealed that Resident R1 and Resident R2 were assessed as cognitively intact and admitted having given their debit and EBT cards to Employee E16 to purchase outside food for them as well as for herself. During interview nurse aide, Employee E16 stated she was unaware her action were in the category of misappropriation of property. The facility concluded that the allegation of misappropriation of property was found substantiated.</p> <p>Continued review of the investigation revealed a statement by Director of Guest Service, Employee E17, which stated it was brought to the administration by two separate staff members, that CNA (nurse aide), Employee E16, was utilizing Patient EBT and debit cards to purchase outside food items at the request. In some instances, Employee 16 was purchasing items for herself using the patient's money. Administration, and patient relations conducted interviews with two patients .one with a BIMS score of 14 the second being resident . BIMS score of 15. At time of interview [Resident R1] admitted giving his EBT card and [Resident R22] admitted giving his debit card to the certified nursing assistant [Employee E16], question in order for her to purchase outside food for him and giving permission to her to purchase items for herself.</p> <p>Review of Resident R1's Minimum Data Set (MDS-assessment of resident care needs) for Resident R1 dated August 5, 2024 revealed that the resident was admitted to the facility on [DATE] with diagnoses of diabetes (a disease characterized by high blood sugar levels, caused by problems with the pancreas or insulin resistance), hyperlipidemia (condition where there are abnormally high levels of lipids or fats in the blood) and schizophrenia (mental condition characterized by hallucinations ,delusions, disorganized thinking and behavior). Resident R1 was cognitively assessed to possess a BIMS (brief interview for mental status) score of 12 , indicating Resident R1 has moderate cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of the investigation indicated the investigation did not include pertinent information such as staff statements, interviews with any other residents that Employee E16 cared for and did not include the amount of funds that were used by Employee E16 .</p> <p>Interview with Director of Nursing Employee E2 on November 22, 2024, at 10:55 a.m. revealed that the residents involved admitted to giving consent for Employee E16 to purchase food for herself. There were no other residents interviewed.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.12(d)(5) Nursing services</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508</p> <p>Based on a review of clinical records, review of the Resident Assessment Instrument and staff interviews, it was determined that the facility failed to conduct a significant change Minimum Data Set Assessments (MDS - a federally mandated standardized assessment process conducted at specific intervals to plan resident care) for a resident who had a deterioration in Range of Motion (ROM) and in Activities of Daily Living (ADL) for one of twenty residents reviewed (Resident R67).</p> <p>Findings include:</p> <p>Review of the RAI (Resident Assessment Instrument) Manual revealed that A significant change is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not self-limiting 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan.</p> <p>Review of Resident R67's clinical record revealed that Resident R67 was admitted to the facility on [DATE], with diagnoses of HIV (human immunodeficiency virus), paraplegia (paralysis on the lower part of the body), and pressure ulcer of the right hip, Stage 4 (ulcer involving loss of skin layers, exposing muscle).</p> <p>Review of admission MDS dated [DATE], revealed that section GG0115 (Functional Limitation in range of motion)</p> <p>A. Upper extremity (shoulder, elbow, wrist, hand) was coded: 0 (no impairment) and B. Lower extremity (hip, knee, ankle, foot) was coded 0 (No impairment)</p> <p>Review of Other State Optional (OSA) MDS dated [DATE], revealed that section G0110. Activities of Daily Living (ADL) Assistance, A. Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture, was coded Limited assistance - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance with One-person physical assist</p> <p>B. Transfer - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet) was coded Limited assistance - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance with One-person physical assist</p> <p>H. Eating - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration) was coded Independent - no help or staff oversight at any time.</p> <p>(continued on next page)</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>I. Toilet use - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag was coded Extensive assistance - resident involved in activity; staff provide weight-bearing support with One-person physical assist</p> <p>Total dependence - full staff performance every time during entire 7-day period with Two+ person physical assist</p> <p>Review of quarterly MDS dated [DATE], revealed that section GG0115 (Functional Limitation in range of motion)</p> <p>A. Upper extremity (shoulder, elbow, wrist, hand) was coded: 0 (no impairment) and B. Lower extremity (hip, knee, ankle, foot) was coded 0 (No impairment)</p> <p>Review of Other State Optional (OSA) MDS dated [DATE], revealed that section G0110. Activities of Daily Living (ADL) Assistance,</p> <p>A. Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture, was coded Extensive assistance - resident involved in activity; staff provide weight-bearing support with Two+ person physical assist</p> <p>B. Transfer - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet) was coded Extensive assistance - resident involved in activity; staff provide weight-bearing support with Two+ person physical assist</p> <p>H. Eating - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration) was coded</p> <p>Supervision - oversight, encouragement or cueing with one-person physical assist</p> <p>I. Toilet use - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet Supervision - oversight, encouragement, or cueing; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag was coded Total dependence - full staff performance every time during entire 7-day period with two+ person physical assist.</p> <p>Interview with Register Nurse Assessment Coordinator, Employee E13 conducted on November 21, 2024, at 12:57 PM revealed that a Significant Change Assessment should have been completed for Resident R67 when the changes were identified during the quarterly MDS assessment dated [DATE].</p> <p>28 Pa. Code 211.12(c)(d)(3)(5) Nursing services</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508</p> <p>Based on observations, clinical record review, it was determined that the facility failed to develop a baseline care plan within 48 hours of admission related to oxygen therapy for one of 20 residents reviewed (Resident R75).</p> <p>Findings include:</p> <p>Review of facility policy on person centered care plan with the most recent revision date of October 24, 2022, revealed that under section Policy: The Center must develop and implement a baseline person-centered care plan within 48 hours of admission/readmission for each resident that includes the instructions needed to provide effective and person-centered care that meets professional standards of quality care.</p> <p>Observation conducted during tour of the fourth-floor unit conducted on November 19, 2024, at 10:34 AM revealed that Resident R75 was in bed. Further Resident R75 was on Oxygen via Tracheostomy collar connected to an Oxygen concentrator. Further, the Oxygen concentrator was running at 3 liters/minute.</p> <p>Follow-up observation conducted on November 22, 2024, at 9:56 am revealed that Resident R75 was in bed asleep. Further observation revealed that Resident R75 was on Oxygen via Tracheostomy Collar connected to an oxygen concentrator.</p> <p>Review of Resident R75's clinical record revealed that Resident R75 was admitted to the facility on [DATE], with diagnoses of but not limited to Chronic Obstructive Pulmonary Disease (COPD) with tracheostomy.</p> <p>Review of Resident R75'd Physician's orders revealed an order for: O2 (oxygen) concentrator set to 6 liters/min every day and night shift- Start Date10/31/2024.</p> <p>Review of admission MDS (minimum data set-a federally required resident assessment conducted at a specific interval) dated November 7, 2024, section O0110 (Special Treatments, Procedures, and Programs), C1(Oxygen) revealed that Resident R75 was on oxygen on admission and while a resident.</p> <p>Further review of Resident R75's care plan for COPD revealed that the care plan was developed and initiated on November 3, 2024, more than 48 hours after Resident R75 was admitted to the facility.</p> <p>Further review of Resident R75's clinical record revealed no documented evidence that a baseline care plan was developed within 48 hours of Resident R75's admission to the facility</p> <p>28 Pa. Code 211.5(f)(viii) Medical records</p> <p>28 Pa. Code 211.12(d)(5) Nursing services</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508</p> <p>Based on review of facility policy, review of clinical records, observation, and staff interview, it was determined that the facility failed to develop and implement a comprehensive care plan related to indwelling catheter for one of 20 residents reviewed (Resident R22).</p> <p>Findings include:</p> <p>Review of facility policy on person centered care plan with the most recent revision date of October 24, 2022, revealed that under section Policy: A comprehensive individualized care plan will be developed within seven days after completion of the comprehensive assessment and review and revise the care plan after each assessment. The care plan will be prepared by the interdisciplinary team.</p> <p>Review of Resident R22's clinical record revealed that Resident R22 was admitted to the facility on [DATE], with diagnoses of Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side (paralysis/weakness to one side of the body), Chronic Kidney Disease, Retention of Urine Unspecified.</p> <p>Review of Resident R22's physician's orders revealed an order dated March 13, 2024, for Indwelling urinary catheter 16 F R with 10cc balloon to bedside straight drainage for diagnosis/Hx (history of) urinary retention.</p> <p>Further review of Resident R22's physician's orders revealed an order dated March 13, 2024, to empty urinary catheter drainage bag at least once every eight hours to when it becomes 1/2 to 2/3 full every shift and as needed.</p> <p>Review of Resident R22's MDS (minimum data set- a federally required assessment conducted at a specific interval) dated September 25, 2024, section H0100 (Appliances), A. (Indwelling catheter-including suprapubic catheter and nephrostomy tube) was coded as yes.</p> <p>Further review of Resident R22's clinical record revealed no documented evidence that a care plan addressing Resident R22's urinary catheter was developed and implemented.</p> <p>Observation on Resident R22 conducted on November 19, 2024, at 1:54 p.m. revealed that resident had tubing connected to a urine bag hanging under Resident R22's bed. Further, the urine bag had 350 cc of yellowish colored clear liquid inside.</p> <p>Interview with Resident R22 conducted at the time of observation revealed that Resident R22 had a urinary catheter in place.</p> <p>28 Pa. Code 211.10 (c) Resident care policies.</p> <p>28 Pa. Code 211.10 (d) Resident care policies.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46993</p> <p>Based on review of facility provided documentation, review of clinical records and interview with staff, it was determined that facility failed to update care plans related to bleeding, weight loss, tube feed occlusion, advanced directives, and hospice care for three out of 22 residents reviewed. (Resident R63, R86, R15)</p> <p>Findings include:</p> <p>Review of facility provided policy 'Person Centered Care Plan,' revised on [DATE], indicates that a comprehensive, individualized care plan will be developed within seven days after completion of the comprehensive assessment (admission, annual or significant change in status) and review and revise the care plan after each assessment. After each assessment means after each assessment known as the Resident Assessment Instrument (RAI) or Minimum Data Set (MDS).</p> <p>Review of Resident 63's nurses notes dated [DATE], revealed a general note stating met with patients fiance accompanied by patient relations director related to issues noted. Despite repeated education and counseling patient's fiance continues to perform interventions that could cause negative Patient outcomes. Discussed administration of over the counter medications like elderberry via peg tube. Counseled on the side effects which include nausea vomiting and diarrhea. Explain that it can also cause increased bleeding. Also related that the nature of the capsules that contain time release beads that may be the reason the peg tube is clogging if it is not flushed well, and the continuous water bolus is interrupted Fiance counseled when infection control practices related to wound care and suctioning discussed aspiration history and requested her to refrain from brushing his teeth and rinsing his mouth with water increasing the risk.</p> <p>Review of Resident R63's care plan revealed the resident has extensive care needs that require medical skills. The resident is at risk for constipation related to a contracture and impaired mobility, risk for secondary complications related to recent hospitalization for abscess and osteomyelitis (bone infection). Resident R63 has documented pressure ulcers, Resident is at risk for altered fluid balance related to congestive heart failure excessive body/lung fluid caused by a weakened heart muscle), risk for infection related to wounds. Resident 63 requires assistance is dependent for ADL (activities of daily living) care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, to transfer, locomotion, and toileting. Resident R 63 is at risk for cardiovascular symptoms or complications related to history of cardiac arrest and congestive heart failure. Resident R63 has impaired cognition function or impaired thought process related to a condition other than delirium, anoxic brain injury. The resident has impaired communication related to a anoxic brain injury (a loss of oxygen supply to the brain) and being nonverbal, risk for falls related to contractures and impaired mobility. The resident has an eternal feeding tube to meet nutritional needs dysphasia (difficulty swallowing) related to anoxic brain injury, risk for injury or complications related to the use of anticoagulation therapy related to DVT (deep vein thrombosis- blood clots within the vein) prophylaxis. The resident is at risk for colonization/ infection due to ventilator dependent device and peg tube. Resident exhibits or is at risk for respiratory complications related to history of respiratory failure, and risk for seizure activity related to a history of seizures.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Resident R63's significant other on November 19, 2024 at 11:10 a.m. revealed that she is present every day and helps with his care.</p> <p>Observation at the time of the interview with resident significant's other, revealed, this visitor covering Resident R63's tracheostomy, (which forces air to exit through the mouth, allowing to produce sound). Interview with visitor at time of interview revealed that she has no concerns of the care he is receiving. This visitor stated that she is present every day and helps with his care. She also stated that she has had a few issues before but has spoken with the administration and any problems have been resolved.</p> <p>Review of Resident R63 nursing notes dated [DATE], revealed Resident R63's girlfriend was brushing his teeth. The visitor was educated on the possible complications and danger of brushing his teeth could cause the resident aspirating.</p> <p>Further review of nursing note dated [DATE] revealed during morning medication rounds I entered the room and the patient girlfriend was flushing him with water, I asked what is that, and why are you touching his G-tube? She stated that she was given him Eldeberry over the counter medication. Education given.</p> <p>Interview with Director of Nursing, Employee E2 at 9:25 a.m. [DATE], confirmed that the visitor providing care is not facility policy and has been addressed. The interdisciplinary team, residents' family and girlfriend recently conducted a care conference and addressed the concerns of this visitor providing care for Resident R63. The visitor agreed not to provide any more care. The certified nursing assistants have instruction to monitor more vigilantly when the visitor is in the room.</p> <p>Resident R 63's care plan has not been updated to reflect the need of supervision for the resident's visitor providing medical care.</p> <p>Review of R15's clinical record revealed a medical diagnosis of long term use of anticoagulant (blood thinners) since [DATE], abnormal weight loss from [DATE], abnormal uterine and vaginal bleeding on [DATE].</p> <p>Further review of Resident R15's clinical record revealed a progress note, dated [DATE] at 8:56 a.m., indicating [AGE] year old female resident was seen for follow up after vaginal bleeding.</p> <p>Further review of R15's progress note, dated [DATE], revealed that patient has recently had a significant weight loss from 120 lb (pounds) in May to 101 lbs in October.</p> <p>Review of R15's care plan on [DATE], revealed no evidence of updates and interventions related to R15's history of bleeding and weight loss.</p> <p>Review of Resident R86's closed clinical revealed Resident R86 was admitted to the facility on [DATE] with the following diagnoses: heart failure; end stage renal disease requiring renal dialysis and intestinal obstruction. Resident R86's advance directive indicated full code and plan to discharge home after short term stay.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of Resident R86's closed clinical record revealed Resident R86 was signed onto hospice care on [DATE]. Further review of Resident R86's closed clinical record revealed the care plan was not updated with significant changes to include updated advance directive (do not resuscitate/do not intubate) and admission to hospice care. Resident R86 expired at the facility on [DATE].</p> <p>28 Pa. Code 211.10(b)(c) Resident care policies</p> <p>28 Pa. Code 211.11 (b)(c) Resident care plan</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0680</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the activities program is directed by a qualified professional.</p> <p>46993</p> <p>Based on interview with staff and review of facility provided documentation, it was determined that the facility activities program was not directed by a qualified professional as required.</p> <p>Findings include:</p> <p>Interview with the nursing home administrator (NHA) on November 19, 2024 at 10:00 a.m., stated that facility currently does not have an activities program director.</p> <p>Interview with Regional staff, Director of guest services, employee E17, on November 20, 2024 at 1:00 p.m., confirmed that facility currently does not have a qualified activities director.</p> <p>Review resident council meeting minutes, dated June 26, 2024, indicates that topics/issues discussed were related to what we can do while outside.</p> <p>Review of resident council meeting minutes, dated July 31, 2024, indicates topics/issues discussed related to 'celebrating birthdays - both for patients and staff.'</p> <p>28 Pa Code 201.189(e)(6) Management</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508</p> <p>Based on observations, review of clinical records, review of facility policy and interview with staff, it was determined that the facility failed to administer oxygen as ordered by the physician for one of three residents on oxygen therapy. (Resident R75)</p> <p>Findings include:</p> <p>Review of Resident R75's clinical record revealed that Resident R75 was admitted to the facility on [DATE], with diagnoses of Chronic Obstructive Pulmonary Disease (COPD) with tracheostomy.</p> <p>Review of Resident R75's physician's orders revealed an order for O2 (Oxygen) concentrator set to 6 liters/min every day and night shift-Start Date 10/31/2024.</p> <p>Review of admission MDS (minimum data set-a federally required resident assessment conducted at a specific interval) dated November 7, 2024, section O0110 (Special Treatments, Procedures, and Programs), C1(Oxygen) revealed that Resident R75 was on oxygen on admission and while a resident.</p> <p>Review of Resident R75's care plan for COPD, revealed an intervention to administer oxygen as ordered/indicated.</p> <p>Observation conducted during tour of the fourth-floor unit conducted on November 19, 2024 at 10:34 AM revealed that Resident R75 was in bed. Further Resident R75 was on Oxygen via Tracheostomy connected to an Oxygen concentrator. Further, the Oxygen concentrator was running at 3 liters/minute.</p> <p>follow-up observation conducted on November 22, 2024, at 9:56 am revealed that Resident R75 was in bed asleep. Further observation revealed that Resident R75 was on Oxygen via Tracheostomy connected to an Oxygen concentrator. Further, the Oxygen concentrator was running at 3 liters/minute</p> <p>Interview with Licensed nurse, Employee E12 conducted on November 22, 2024, at 10:01 am confirmed that Resident R75's oxygen was running at 3 liters/minute. Further Employee E12 reviewed Resident R75's physician order for oxygen and revealed that the order was for 6 liters/ minute. Employee E12 then proceeded to adjust Resident R75's Oxygen level to 6 liters/minute.</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p> <p>28 Pa. Code 211.12(d)(5) Nursing services</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>46993</p> <p>Based on a review of personnel files and interviews with staff, it was determined that the facility did not ensure that nursing staff had specific competencies and skills sets necessary to care for residents' needs for three out of five personnel files reviewed. (Employees E9, E18, E16)</p> <p>Findings include:</p> <p>Review of Employee E9's personnel file revealed that the employee was hired on October 1, 2024 by the facility as licensed nurse. Continued review revealed that there was no indication that the employee received skill competency training related to resident rights, person centered care, communication, basic nursing skills, basic restorative services, skin and wound care, medication management, pain management, infection control, identification of changes in condition, and cultural competency.</p> <p>Review of Employee E18's personnel file revealed that the employee was hired on August 21, 2024 by the facility as nurse aide. Continued review revealed that there was no indication that the employee received skill competency training related to resident rights, person centered care, communication, basic nursing skills, basic restorative services, skin and wound care, medication management, pain management, infection control, identification of changes in condition, and cultural competency.</p> <p>Review of Employee E16's personnel file revealed that the employee was hired on June 21, 2024 by the facility as nurse aide. Continued review revealed that there was no indication that the employee received skill competency training related to resident rights, person centered care, communication, basic nursing skills, basic restorative services, skin and wound care, medication management, pain management, infection control, identification of changes in condition, and cultural competency.</p> <p>Findings confirmed with facility's Nursing Home Administrator and Director of Nursing on Friday, November 22, 2024 at 2:45 p.m.</p> <p>28 Pa Code 201.19(7) Personnel policies and procedures</p> <p>28 Pa Code 211.12(d)(2)Nursing services</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>29720</p> <p>Based on staff interviews and a review of employee credentials, it was determined that the facility failed to employ a qualified director of food and nutrition services, as required (Employee E8)</p> <p>Findings include:</p> <p>Observation tour on November 19, 2024 at 10:00 a.m. with Employee E8, Food Service Director (FSD) stated that his responsibilities included the oversight of ordering, receiving, storing and preparation and service of food and that he had been working at the facility for one and one half years.</p> <p>Interview on November 19, 2024 at 1:00 p.m. with Employee E8 , Food Service Director, confirmed that he was not a certified dietary manager (CDM); or a certified food manager (CFM); or had a national certification for food service management and safety from a national certifying body; or had an associate's or higher degree in food service management or hospitality from an accredited institution; and that he had not received frequently scheduled consultations from a qualified dietician.</p> <p>Review of Employee E8's credentials revealed that Employee E8 did not meet the statutory qualifications of a director of food and nutrition services.</p> <p>Interview on November 20, 2024 at 10:30 a.m. revealed that a corporate Registered Dietician (RD), Employee E5 covers the building two days per week and that the former RD had been assigned to another building. The Nuring Home Administrator was unable to provide evidence that the FSD was receiving frequently scheduled consultation from a qualified dietician to ensure that adequate guidance was provided to the FSD and staff of the dietary department.</p> <p>28 Pa Code 201.18(b)(3)(e)(1)(6) Management</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508</p> <p>Based on observations, review of facility policies, review of clinical record and interviews with staff, it was determined that the facility failed to maintain effective infection control practices related to barrier precautions and personal protective equipment for one of one resident observed (Residents R52).</p> <p>Findings include:</p> <p>Review facility policy on Enhanced Barrier Precautions (EBP) with revision date of March 1, 2022, revealed that under section Policy: In addition to standard precautions Enhanced Barrier Precautions will be used when contact precautions do not otherwise apply for novel or targeted multi drug resistant organisms. Enhanced Barrier Precautions is based on the Centers for Disease Control and Prevention, (CDC) guidance, implementation of personal protective equipment (PPE- refers to protective items or garments worn to protect the body or clothing from hazards that can cause injury and to protect residents from cross-transmission) used in nursing homes to prevent the spread of multi drug resistant organisms, updated July 12, 2022, and the accompanying Frequently Asked Questions document. State regulations will be followed when applicable. Under section Purpose: To reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact.</p> <p>Review of Resident R52's clinical record revealed that Resident R52 was admitted to the facility on [DATE], with diagnoses of Cervical Disc Disorder with Myelopathy (a nervous system disorder that can affect the spinal cord), Cervical Disc Disorder at C6-C7 level with Radiculopathy (compression of the nerve), Type 2 Diabetes Mellitus (failure of the body to produce insulin to enable sugar to pass from the blood stream to cells) with Diabetic Neuropathy.</p> <p>Review of Resident R 52's wound care progress notes dated November 20, 2024, revealed the following:</p> <p>Wound #1 Left Hip is a Stage 4 Pressure Injury Pressure Ulcer. Initial wound encounter measurements are 4.5 centimeter (cm) length x 5cm width x 1.8 cm depth, with an area of 22.5 sq cm and a volume of 40.5 cubic cm. Muscle is exposed. There is a Moderate amount of serous drainage noted.</p> <p>Wound #2 Sacral is a Stage 4 Pressure Injury Pressure Ulcer. Initial wound encounter measurements are 5cm length x 12cm width x 2.5 cm depth, with an area of 60 sq cm and a volume of 150 cubic cm. There is a moderate amount of serous drainage noted.</p> <p>Wound #6 Right, Lateral Lower Leg is a Stage 4 Pressure Injury Pressure Ulcer. Initial wound encounter measurements are 14cm length x 4cm width x 0.4 cm depth, Undermining has been noted at 6:00 and ends at 12:00 with a maximum distance of 2cm. There is a moderate amount of serous drainage noted.</p> <p>Wound #7 Left, Lateral Lower Leg is an Unstageable/Unclassified Pressure Ulcer. Initial wound encounter measurements are 5cm length x 1.5cm width x 0.5 cm depth, with an area of 7.5 sq cm and a volume of 3.75 cubic cm. There is a Light amount of serous drainage noted which has no odor.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Physician's orders revealed an order for Santyl External Ointment 250 UNIT/GM (Collagenase) Apply to sacrum topically every day and night shift for wound care-Start Date-11/21/2024</p> <p>Wound is to be cleaned with Vashe solution-, Santyl ointment used inside wound and packed saline soaked gauze and covered with Clean dry dressing every day and night shift-Start Date-11/16/2024 1900</p> <p>Observation of Resident R52's room conducted on November 22, 2024, at 11:39 am revealed that there was no Enhanced Barrier Precaution signage posted outside Resident R52's room.</p> <p>Further observation reveled that there was no bin inside Resident R 52's room where staff can discard used PPE, after providing care to Resident R52 that required the use of PPE as per EBP protocol.</p> <p>Wound care observation Resident R52 conducted on November 22, 2024, at 11:39 AM with licensed nurse Employee E9 revealed that Employee E9 was wearing a mask and a pair of gloves.</p> <p>Further, observation revealed that Employee E9 started performing wound dressing on Resident R52 without donning a gown.</p> <p>Interview with Licensed nurse, Employee E9 regarding facility policy on EBP conducted at the time of the observation revealed that according to facility policy, she did not have to wear a gown and that she only needed to wear a mask and gloves.</p> <p>Further observation reveled that, Employee E9 proceeded to perform wound care on Resident R52 without wearing a gown.</p> <p>Interview with the Infection Preventionist Employee E10 conducted on November 22, 2024, at 12:02 pm revealed that for EBP, it is only necessary to wear a gown when providing care for on residents with-feeding tube, tracheostomy, foley catheter and wound with drainage. Further Employee E9 also revealed that for wounds that does not have drainage, there is no need to wear gowns.</p> <p>Interview with Director of Nursing, Employee E2 conducted on November 22, 2024, conducted during exit conference revealed that the facility does not require staff to wear a gown when providing wound care on dry wounds.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.10(d) Resident care policies</p> <p>28 Pa. Code 211.12(c)(d)(1)(5) Nursing Services</p>		

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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 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>46993</p> <p>Based on observation, interviews with staff and residents and review of facility documentation, it was determined that the facility did not maintain an effective pest control program to ensure that the facility was free of pests for one of four floors. (5th floor)</p> <p>Findings include:</p> <p>Review of facility policy, Preventive Maintenance Policy and Procedure, Review of Infection Control Practices, revised January 8, 2024, revealed: Pest Management: The facility will provide a pest free environment by contract with a pest control vendor for appropriate service on a periodic basis whether weekly, monthly or as needed. As well, all staff are educated in maintaining the proper cleanliness of the facility and storing food in appropriate containers.</p> <p>Interview on November 21, 2024 at 11:00 with Employee E14, Unit Manager of 5th floor, confirmed that there have been multiple mice sightings on the fifth floor. We have a log to document pest sightings and the pest control company treats the area or rooms.</p> <p>Review of the pest control company's reports revealed thirteen sightings from October 15--October 30, 2024 and fourteen sightings from November 1--November 17, 2024.</p> <p>Review of 'pest sighting log book,' on November 19, 2024 at 11:44 a.m., revealed 32 sightings recorded from May 2024 to November 2024.</p> <p>Interview with Resident R6 on November 19, 2024 at 10:30 a.m., revealed facility is infested with pests.</p> <p>Interview with Resident R241 on November 19, 2024 at 9:45 a.m., revealed that mice sightings are frequent.</p> <p>Interview with Resident R52 on November 19, 2024 at 9:50 a.m., revealed that facility is infested with mice.</p> <p>Interview with Resident R243 on November 19, 2024 at 9:55 a.m., revealed that she sees mice on the hallway and a big roach in this room.</p> <p>Interview with Resident R20 on November 19, 2024 at 10:00 a.m., revealed there is mice around here.</p> <p>28 Pa Code 207.2 (e) Administrator's Responsibility</p>		