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	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graduate Post Acute	1526 Lombard Street Philadelphia, PA 19146

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on review of personnel records and interviews with staff, it was determined that the facility failed to complete annual performance reviews for nurse aide staff as required for five of five nurse aide personnel files reviewed (Employees E11, E12, E13, E14 and E15).Findings include:Interview on September 25, 2025, at 10:00 a.m. annual performance evaluations for nurse aide staff, Employee E11, E12, E13, E14 and E15 were requested from the Nursing Home Administrator (NHA) and Director of Nursing (DON).Interview with Regional Staff, Employee E10, on September 25, 2025, at 10:48 a.m. facility did not have records of performance evaluation for Employee E11, E12, E13, E14 and E15.Facility did not submit performance evaluation for Employee E11, E12, E13, E14 and E15 prior to or at the time of the exit conference as requested.28 Pa. Code 201.19(2) Personnel policies and procedures.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, review of facility policy and interviews with staff, it was determined that the facility did not ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety.Findings include: Observations of the dish room conducted on September 22, 2025m at 10:00 a.m. revealed a hole in the ceiling. Interview with the administrator at 10:06 a.m. confirmed the opening g had been exposed for about two weeks, since the pipe was removed. Flies were observed in the dish room and a severe foul odor was present. Observations in the dry storage area revealed boxes and food items were stored all the way to the ceiling with no clearance between the top shelf and the ceiling. Observations in the main cooking area revealed flies and gnats were observed, and a gray trash container was standing by the tray line, filled and uncovered (no lid), while food was being prepared. Interview with the Food Service Director (FSD), Employee E5, throughout the kitchen tour confirmed the above-mentioned findings. FSD stated that the flies come into the kitchen area from the outside receiving area, where the trash room is located. 28 Pa. Code 201.14(a) Responsibility of licensee

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that the rationale and duration for continuing as needed (PRN) psychotropic medication orders beyond 14 days were documented by the prescribing practitioner for one of five residents reviewed. (Resident R123).Findings Include:Record review for Resident R123 revealed multiple PRN orders for Lorazepam (psychotropic medication used to treat anxiety, seizures, and insomnia caused by anxiety) 2 milligrams (mg), to be given by mouth every six hours as needed for anxiety, each entered for a 14-day period as follows:Order started on August 27, 2025 (August 27, 2025 - September 10, 2025)Order started on September 8, 2025 (September 8, 2025 - September 22, 2025)Order active on September 16, 2025 (September 16, 2025 - September 30, 2025)Further review revealed no documentation from the prescriber providing a clinical rationale or justification for the continuation of PRN Lorazepam beyond the initial 14-day limit, nor any indication of the duration for continued use as required.Interview with Director of Nursing, Employee E2 on September 25, 2025, at 11:00 a.m. confirmed that the medication order was renewed for Resident R123 after 14 days of the initial order. Employee E2 confirmed that there was no justification for the continuation of PRN Lorazepam beyond the initial 14-day limit, nor any indication of the duration for continued use.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, staff interview, and clinical record review, it was determined that the facility failed to ensure that interventions related to effective communication for a resident who spoke a language other than English were implemented or one of two residents reviewed (Resident R84).Findings Include: On September 23, 2025, at 10:59 am. observation revealed Resident R84 was unable to speak English and was observed pointing toward their brief, attempting to indicate a need for assistance. There was no evidence of an interpreter line or communication board being used during the interaction. An interview with Nurse Aide, Employee E7, conducted on September 23, 2025, revealed that the resident just uses gestures, and confirmed that the interpreter line and communication board were not utilized with the resident. Review of resident R84's care plan, dated March 31, 2025, indicated the resident required interpreter services as the primary language was not English. The interventions included the use of Video Remote Interpretation services or Language Link as needed to provide adequate communication. Follow-up observations and interview with Nurse Aide, Employee E7, conducted on September 24, 2025, at 1:15 p.m. revealed that the resident revealed frustration while attempting to operate the television remote and was unable to communicate which channel she wanted. Nurse Aide, Employee E7 stated, I try different things until we figure it out. sometimes it's really hard to understand [Resident R84]. Observations at the same time revealed the communication board stored on the closer door, not accessible to the resident. During an interview at 1:30 p.m. with the Director of Memory Care Services, it was stated, we hung up the communication board yesterday. During continued interviews, staff were unaware of the facility's interpreter line or the resident's preferred language. Employee E7 stated, I didn't know that sign is there, and I didn't know there's a communication line, and proceeded to ask what the resident's primary language was. 28 Pa Code 211.10(c) Resident care policies28 Pa Code 211.12(d)(5)(7) Nursing services

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, and interviews with residents, and staff, it was determined that the facility failed to provide the necessary assistance with activities of daily living (ADLs) to maintain proper grooming for two of the two residents reviewed (Residents R6, R94)Findings include:Review of Resident R6 's clinical record revealed the resident was admitted to the facility on [DATE], and had a diagnoses of anterior spinal artery compression syndrome, cervical region, dependence on renal dialysis, heart failure, peripheral vascular disease (disorder that causes narrowing blockage or spasms in blood vessel outside the heart and brain), and legal blindness,A review of Resident R6's annual Minimum Data Set (MDS- assessment of resident care needs), dated July 20, 2025, indicated a Brief Interview for Mental Status (BIMS) score of 13, reflecting cognitive intact. A comprehensive care plan dated June May 06, 2025, indicated an Activity of Daily Living (ADL) goal of bathing needing 1 staff assistance with bathing/showring, for bed mobility requiring assistance of 2 staff for turning and repositioning, for personal hygiene grooming requiring 1 person assistance, oral care requiring 1 person assistance, dependent on staff. An interview was conducted on September 22, 2025, at 1:13 p.m., during which Resident R6 reported, My teeth have not been brushed in weeks. I go for dialysis early in the morning and get up at 4 a.m., and my teeth aren't brushed. Resident R6 had a strong oral odor and was observed covering his mouth.At 1:23 p.m. the same day, an interview was conducted with Nurse aide, Employee E16, who stated that she was assigned to Resident R6 but had not yet provided his care for the day.At 1:55 p.m., an interview with the Administrator, Employee E1, confirmed observations of Resident R6 lying in bed with dirty fingernails, noticeable oral odor, and uncombed hair.On September 24, 2025, at 1:04 p.m., Resident R6 was observed returning from dialysis and reported that he had only received a face wash and a partial bath (waist down) that morning. Oral care had not been provided, and a noticeable oral odor remained.Review of Resident R94's clinical record revealed the resident was admitted to the facility on [DATE], and had a diagnosis of muscle wasting and atrophy, malignant neoplasm of left kidney, and need assistance with personal care.A review of Resident R94's admission MDS, dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 15, reflecting cognitive intact. A comprehensive care plan dated August 21, 2025, indicated an Activity of Daily Living (ADL) goal of ambulation requiring 1 staff assist, dependent on staff for bathing.On September 22, 2025, at 1:43 p.m., an interview was conducted with Resident R94, who had facial hair and greasy hair. The resident stated, My therapist took me out of bed, and I wanted to be placed back after therapy, but they couldn't do it by themselves, so I've been sitting in my chair for two and a half hours because there was no second person available.On September 25, 2025, at 10:55 a.m., a second interview was conducted with Resident R94, who reported that showers are very important to him. He stated that the last time he received a shower was about a month ago. The resident was observed to have greasy hair and facial hair. A licensed nurse, Employee E18, confirmed the observation of facial and greasy hair. The same nurse also verified through the Task Documentation in the clinical record that Resident R94 was scheduled to receive showers on Mondays and Thursdays. However, the showers scheduled for Thursday, September 11; Monday, September 15; and Thursday, September 18 were not completed.28 Pa. Code 211.10 (d) Resident care policies28 Pa code 211.12.(d)(1)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility documentation, and resident and staff interviews, it was determined that the facility failed to provide quality care related to wound care and medication administration for two of eight residents reviewed (Residents R100, R151).Findings include:Clinical record review revealed Resident R100 was admitted to the facility on [DATE] with a diagnosis that included surgical amputation, type 2 diabetes mellutis (failure of the body to produce insulin) with diabetic peripheral angiopathy with gangrene (a severe complication of diabetes where poor circulation (peripheral angiopathy) leads to tissue death (gangrene) in the limbs, most commonly the feet), and panlobular emphysema (a type of chronic obstructive pulmonary disease characterized by the destruction of the alveoli (air sacs) throughout the entire lung lobule). Interview with Resident R100 on September 23, 2025 at 11:22 a.m. revealed staff has not changed his/her wound dressings in 2 days.Observation on September 23, 2025 at 11:26 a.m. revealed Resident R100's left foot wound dressing was dated September 20, 2025.Review of Resident R100's physician orders, dated August 22, 2025, revealed an order to change negative pressure wound therapy (also known as wound vac-helps a wound heal faster by removing fluid and bacteria with suction) dressing every 3 days and PRN (as needed) every day shift every Mon, Wed, Fri for left foot wound.Review of Resident R100's Septmber 2025 TAR (treatment administration record) revealed the resident did not receive wound care on the scheduled days of September 19, 2025 and September 22, 2025 as ordered.Review of Resident R100's physician orders, dated September 12, 2025, revealed an order to cleanse right 4th toe with wound cleanser, pat dry, apply small amount of santyl, calcium alginate, abd pad, wrap with kling daily and prn everyday shift for diabetic pressure ulcer.Review of Resident R100's TAR revealed the resident did not receive daily wound care on September 18, 2025, September 21, 2025 and September 22, 2025 as ordered.Interview on September 23, 2025 at 11:35 a.m. with Employee E3, Licensed Nurse, revealed Resident R100 did not receive wound care on the dates listed above based on the TAR and date listed on Resident R100's wound dressing.Clinical record review revealed Resident R151 was admitted to the facility on [DATE] with a diagnosis that included osteomyelitis of vertebra (infection of vertebra), malignant neoplasma of unspecified part of unspecified bronchus or lung (cancerous tumor in the lung/and or broncus), and orthostatic hypotension (lower blood pressure).Interview with Resident R151 on September 22, 2025 at 12:50 p.m. revealed the resident does not receive his/her medication timely. Observation on September 22, 2025 and September 23, 2025 at approximately 11:00 a.m. revealed Resident R151 receiving his/her scheduled 9:00 a.m. medication.Review of Resident R151's clinical record revealed a physician order, dated September 20, 2025, for Midodrine HCl Oral Tablet 2.5 MG (Give 1 tablet by mouth three times a day for Orthostatic Hypotension hold for systolic blood pressure (top number in a blood pressure reading, indicating the pressure in the arteries when the heart beats) greater than 120). Review of Resident R151' MAR (medication administration record) revealed Midodrine was administered on the following dates with systolic blood pressure being over 120:September 20, 2025 9:00 a.m.- BP 147/651:00 p.m.- BP 147/659:00 p.m.- BP 139/67September 21, 20251:00 p.m.- BP 129/639:00 p.m.- BP 127/72Interview on September 24, 2025 at 10:50 a.m. with Employee E3, License Practical Nurse, confirmed the medication was administered when Resident R151's systolic blood pressure was above 120. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on clinical record review and staff interviews, the facility failed to ensure that resident weights were obtained as ordered to monitor nutritional status for one of 25 residents reviewed (Resident R7)Findings Include:Record review for Resident R7 dated June 3, 2025, revealed that the physician recommended to monitor weight.Record review for Resident R7 dated July 11, 2025, revealed that the physician recommended to monitor weight and it was revealed an order was placed for monthly weights.Review of physician order for Resident R7 dated July 9, 2025, revealed an order for monthly weights on 15th of every month.Review of the resident's weight documentation showed that no weights were recorded for the months of June 2025, July 2025 and August 2025, as ordered.Review of weight for Resident R7 revealed that on May 7, 2025, the resident weighed 137.6 lbs. and on September 18, 2025, resident weighed 116 pounds representing a 15.7% weight loss over the periodReview of nutritional progress note for Resident R7 dated September 19, 2025, revealed that the resident triggered for significant weight loss of -21.8lb (15.8%) x 5 months. It was documented that the reweight to confirm the weight loss was pending. It was also documented that the weight loss would be unplanned/unfavorable.Review of weight for Resident R7 revealed that there was no re-weights documented as of September 24, 2025.Interview with the Dietician, Employee E6 on September 24, 2025, at 1:00 p.m., confirmed that the ordered weights were not consistently obtained and there was no reweight completed as of September 24, 2025, to confirm weight loss for Resident R7.28 Pa. Code 211.12(d)(3) Nursing services.28 Pa. Code 211.12(d)(5) Nursing services

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observations, reviews of clinical records and review of facility policies and procedures, it was determined that the facility failed to provide adequate treatment, assessment and monitoring for the care and maintenance of mid line catheter line in accordance with professional standards of practice for one of one residents reviewed for intravenous catheter care. (Resident R30).Findings include:Review of facility policy Peripheral and Midline (A a long (3 to 8 inches, or 7 to 20 centimeters) thin, soft plastic tube that is put into a small blood vessel) IV (intravenous) Dressing Changes, dated October 2024, revealed that 1. Perform site care and dressing change at established intervals or immediately if the integrity of the dressing is compromised (e.g., damp, loosened or visibly soiled).2. Maintain sterile dressing (transparent semi-permeable membrane [TSM] dressing or sterile gauze) for all peripheral catheter sites.3. The type of dressing is based on the condition of the resident and his or her preference. Select a dressing that will minimize the need for dressing disruptions.4. Change the dressing if it becomes damp, loosened or visibly soiled and:a. at least every 7 days for TSM dressing.b. at least every 2 days for sterile gauze dressing (including gauze under a TSM unless the site is not obscured); orc. immediately if the dressing or site appears compromised.Observation of Resident R30 on September 22, 2025, at 1:06 p.m. revealed that the resident had a right upper extremity midline catheter. Documentation on the midline catheter dressing revealed that the midline was last changed on September 12, 2025. Employee E9, Licensed Practical Nurse, who was present during the observation confirmed the finding. Review of clinical record for Resident R30 revealed no evidence that the facility obtained a physician order for the care and assessment of midline catheter and facility completed midline assessment for complications related to midline. Review of clinical record for Resident R30 revealed no evidence that the facility completed midline catheter dressing every seven days as required. Interview with Director of Nursing, Employee E2 on September 25, 2025, at 11:00 a.m. confirmed staff was expected to provide and document midline assessment as well as change midline dressing every seven days. 28 PA. Code: 211.10 (a)(b)(c)(d) Resident care policies.28 PA. Code: 211.12(c)(d)(1)(5) Nursing services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of clinical record, staff interviews and observations, it was determined that the faciity failed to obtain physician orders to administer oxygen via nasal canula for two fo two residents reviewed for respiratory care. (Resident R158 and Resident R100)Findings include: Review of facility policy titled Oxygen Therapy, no date, revealed Oxygen (02) is administered appropriately to residents to improve oxygenation and provide comfort to residents experiencing respiratory difficulties. Oxygen is administered by licensed staff with a physicians order. In an emergency oxygen can be administered and order should be received as soon as possible. Clinical record review revealed Resident R100 was admitted to the facility on [DATE] with a diagnosis that included surgical amputation, type 2 diabetes mellutis with diabetic peripheral angiopathy with gangrene (a severe complication of diabetes where poor circulation (peripheral angiopathy) leads to tissue death (gangrene) in the limbs, most commonly the feet) and panlobular emphysema (a type of chronic obstructive pulmonary disease (COPD) characterized by the destruction of the alveoli (air sacs) throughout the entire lung lobule). Observation on September 22, 2025 at 10:05 a.m. revealed Resident R100 was receiving 3 Liters of oxygen. Review of Resident R100's clinical record revealed no physician order for oxygen to be administered. Interview on September 23, 2025 at 11:45 a.m. with Licensed Practical Nurse, Employee E4, confirmed Resident R100 did not have an order for oxygen to be administered. Observation of Resident R158 on September 22, 2025 revealed that the resident was in bed and was receiving oxygen via nasal canula. The reading on the oxygen concentrator revealed that the resident was receiving oxygen at a rate of 1 L/min(liter/min). Review of physician orders for Resident R158 active on September 22, 2025 revealed no evidence that the facility obtained a physician order for oxygen administration. Interview with Employee E2, Director of Nursing, on September 25, 2025 at 11:00 a.m. confirmed that there was physician order to administer oxygen to Resident R158.28 Pa. Code 211.12(d)(1) Nursing services28 Pa. Code 211.12(d)(5) Nursing services

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on the review of clinical records and interviews with staff and resident, it was determined that the facility failed to ensure that pain management was provided consistently as ordered by the physician for one of two residents reviewed for pain management. (Resident R123)Findings include:Interview with Resident R123 on September 22, 2024, at 1:03 p.m. revealed that she was not receiving pain medication as ordered. She stated when she was not receiving pain medication when her pain level was 10 of a scale of 10. Resident stated that staff told her that the medication which was ordered by the physician was not available from the pharmacy.Review of physician orders for Resident R123 dated September 4, 2025, revealed orders for Oxycontin (Narcotic pain medication) extended release 20 mg every 12 hours for pain.Review of Medication Administration Record for the month of September 2025 revealed that on September 20, 2025, at 9:00 p.m., September 21, 2025, at 9:00 a.m., and September 21, 2025, at 9:00 p.m., resident did not receive Oxycontin as ordered by the physician.Interview with the Registered Nurse, Employee E9 on September 22, 2025, at 1:05 p.m., confirmed that Resident R123 did not receive pain medication as ordered by the physician.28 Pa. Code 211.10(c) Resident care policies28 Pa. Code 211.12(d)(1) (5) Nursing services

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, staff and resident interviews, it was determined that the facility failed to provide culturally competent, trauma care in accordance with professional standards of practice, accounting for the resident's past experiences and preferences in order to eliminate and/or mitigate triggers that may cause re-traumatization of the resident for two of two residents sampled for post-traumatic stress disorder(PTSD). (Resident R4 and R104).Findings include:A review of the clinical record revealed that Resident R4 was admitted to the facility, with diagnoses to include non-traumatic subarachnoid hemorrhage(a collection of blood that accumulates between the inner layer of the skull), major depressive disorder (a common mental health condition characterized by persistent feelings of sadness, loss of interest, and low energy levels that can significantly impact daily life and post-traumatic stress disorder (PTSD)(a mental health condition that develops after experiencing or witnessing a traumatic event, such as a natural disaster, war, violent crime, or personal loss)Resident R4's current care plan, dated September 25, 2025, revealed no care plan developed for history of traumatic events. Further review of the care plan did not address possible triggers that may cause re-traumatization.Interview with the Director of Nursing, Employee E2, on September 25, 2025, at 11:00 a.m. confirmed that Resident R4's care plan did not include PTSD and possible triggers that may cause re-traumatization. Clinical record review revealed Resident R104 was admitted to the facility on [DATE] with a diagnosis that muscle wasting and atrophy (thinning or wasting of muscle tissue), heart failure (condition in which the heart cannot pump efficiently enough to meet the body's need for blood), and post traumatic stress disorder. Review of Resident R104's care plan revealed no care plan was developed for the resident's diagnosis of post traumatic stress disorder and possible triggers that may cause re-traumatization. Interview with the Director of Nursing, Employee E2, on September 25, 2025, at 11:00 a.m. confirmed that Resident R104's care plan did not include PTSD and possible triggers that may cause re-traumatization. 28 Pa. Code 211.12(c)(d)(3)(5) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on review of clinical records and staff interviews, it was determined that the facility failed to ensure a response to the consultant pharmacist's recommendation related to the potentially unnecessary medications in a timely manner for one of five residents reviewed. (Resident R7)Findings include: Review of pharmacy consultant report for June 20, 2025, revealed a pharmacy consultant recommendation for Resident R7 which stated, Currently receiving Wellbutrin can contribute to difficulty sleeping of dosed at bedtime. Please consider changing the time to 9:00 a.m. Further review of the recommendation revealed that the recommendation was acknowledged and signed. There was no evidence that the facility implemented the recommendation until September 24, 2025, after the pharmacy review was requested by the survey team. Review of pharmacy consultant report for July 30, 2025, revealed a pharmacy consultant recommendation for Resident R7 which stated MD order indicate medications may be crushed. Resident is receiving medication(s) which should not be crushed. Please update these orders to include: DO NOT CRUSH statement. If the resident is unable to take medication whole please see suggestions below. 1.Bupropion XL- can be changed to immediate release tablets, dosed per psych Further review of the recommendation revealed that the recommendation was acknowledged and signedReview of physician order revealed that the medication order did not include DO NOT CRUSH statement until August 31, 2025. Further review of the physician orders revealed that medication was continued as extended-release tablet and was given half. There was no documented reason for not following pharmacist recommendation. 28 Pa. Code 211.9(k)Pharmacy services28 Pa. Code 211.12(d)(3) 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	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graduate Post Acute	1526 Lombard Street Philadelphia, PA 19146

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observations and an interview with staff it was determined that the facility did not ensure that garbage and refuse was disposed of properly.Findings include: Observations of the trash room conducted on September 22, 2025, at 10:15 a.m. revealed that the trash room door was open and the trash bins were exposed; two large trashcans were overflowing with refuse exposed to open air, and severe foul odor was observed. Continued observations revealed dirty gloves, debris, food, were scattered on the floor around the trash bins. Observations in the receiving area revealed four uncovered grey trash bins exposed and filled with trash. A foul, white, milky liquid was observed pooling across the receiving area floor. The liquid appeared to be leaking from the construction trash container and had spread into multiple walking and delivery zones used by staff to transport food into the facility. Continued observations confirmed trash from the kitchen was mistakenly placed in the construction trash bin. Flies were observed in the receiving area, in the trash room and construction trash container, and at the receiving entrance door. A strong, pervasive odor was present throughout the receiving area, consistent with decomposing waste. Interview with Food Service Director, Employee E5 along duration of the tour confirmed observations of the receiving and dumpster area. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 207.2(a) Administrator's responsibility