

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Ivy Hill Post Acute Nursing & Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Ivy Hill Road Philadelphia, PA 19150	

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 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** 47968</p> <p>Based on a review of clinical records, facility documentation, and interviews with staff, it was determined that the facility failed to review and revise comprehensive person-centered plan of care in a timely manner, for one of 28 resident records reviewed (Residents R384).</p> <p>Findings include:</p> <p>Review of Resident R384's clinical records revealed an admitted [DATE].</p> <p>Review of Resident R384's clinical record revealed medical diagnosis of Meniere's Disease, (a rare inner ear condition that affects both balance and hearing), Malignant Neoplasm of Endometrium, (a type of cancer that begins as a growth of cells in the uterus, Hypertension, (high blood pressure), Muscle Weakness, Atrial Fibrillation,(an irregular and often rapid heart rate), Chronic Obstructive Pulmonary Disease, (obstructed airflow from the lungs), Myocardial Infraction, (heart attack), Protein Calorie Malnutrition, Osteoarthritis, (tissue and parts of joints gradually deteriorate), Nontraumatic Intracerebral Hemorrhage in Cerebellum, (bleeding into brain tissue), Acute Embolism and Thrombosis of Left Lower Extremity, (disruption of blood flow), Hearing Loss and Acute Kidney Failure, (condition that occurs when kidneys suddenly become unable to filter waste products from blood).</p> <p>Review of Resident R384's clinical records revealed a care plan dated December 26, 2023, documenting Resident 384 has a code status of full code.</p> <p>Further review of Resident R384's clinical records revealed physician orders documenting Resident R384's code status as DNR/DNI.</p> <p>Review of Resident R384's medical chart failed to reveal a POLST (Physician Order for Life Sustaining Treatment) form.</p> <p>During interview on June 12, 2024, at 1:48 p.m. the Social Worker (SW) stated Resident R384's code status was changed to DNR/DNI when hospitalized on [DATE], due to an Intracranial Hemorrhage.</p> <p>The SW stated Resident R384's representative lived out of the country and the facility initially had difficulty contacting them to confirm the correct facility readmission code status.</p> <p>(continued on next page)</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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The SW stated he/she was eventually able to contact Resident R384's representative via an online app. (an instant messaging and voice over IP service which allows users to send text messages, voice messages, video messages and share documents, images, and other content online).</p> <p>The SW further stated the resident's representative requested additional time to discuss and decide with family Resident R384's code status. Per the SW, on June 11, 2024, a temporary verbal agreement was made to have Resident R384's code status remain as DNR/DNI until a signed, updated, POLST was obtained by the facility.</p> <p>During interview with the SW, it was confirmed that Resident R384's care plan and physician orders did not match and Resident R384's POLST was not current.</p> <p>28 Pa. Code 211.10(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(5) Nursing services</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>06525</p> <p>Based on observations of care and services and interviews with staff, it was determined that the facility failed to assess communication needs and ensure that appropriate treatment and services were provided to maintain the ability to speak and understand the preferred language for one of two residents reviewed. (Resident R10)</p> <p>Findings include:</p> <p>Observations of Resident R10 at 11:15 a.m., on June 10, 2024 revealed that this resident was in need of assistance with bathing, dressing and grooming. Resident R10 was unable to articulate his needs for assistance with activities of daily living.</p> <p>Interview with the licensed nursing staff, Employee E6, at 12:00 noon on June 10, 2024 revealed that Resident R10 was speaking his native language of Cambodian that the nurse could not understand.</p> <p>Clinical record review revealed a care plan for Resident R10 that indicated this resident has a language barrier and communication problem. There were no care plan measures to provide an interpreter for assessment purposes of cognitive ability and quality of life enrichment for Resident R10. There was no documented family/friend contacts for Resident R10.</p> <p>Interview with the Speech/Language Pathologist, Employee E9, at 1:00 p.m., on June 12, 2024 confirmed the lack of assessment and use of assistive devices (language line and interpreter) to comprehensively determine Resident R10's communication abilities in Cambodian, the preferred language of this resident. The Speech/Language pathologist also confirmed that the interdisciplinary care team failed to determine if Resident R10 wanted an interpreter to communicate with the doctor or healthcare staff.</p> <p>28 PA. Code 211.5(f)(ii)((iv)(vi)(vii)(viii)(ix) Medical records</p> <p>28 PA. Code 201.29(a)(4) Resident rights</p> <p>28 PA. Code 201.14(a) Responsibility of licensee</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>46508</p> <p>Based on observation, review of physician's orders and interview with staff, it was determined that the facility to ensure that physician's order related to tube feeding was followed for one of twenty-eight residents reviewed (Resident R14).</p> <p>Findings include:</p> <p>Review of Resident R14's clinical record revealed a physician's order dated June 9, 2024, for every 4 hours Bolus Feeding: Jevity 1.5 via PEG (percutaneous Gastroscopic Gastrostomy tube- a tube connected to the stomach used to introduce liquid food into the stomach) , 237 ml bolus 6x/day, total volume 1422 ml per 24 hours.</p> <p>Further, a physician's order dated June 9, 2024 for NPO (nothing by mouth) was also in place.</p> <p>Observation conducted during tour of the second floor unit on June 10, 2024 at 9:37 am revealed that licensed nurse Employee E13 was administering a cream-colored liquid into Resident R14's peg tube using a large syringe.</p> <p>Further observation revealed that there was one cup of cream-colored liquid left on the overhead table which the Employee E13 was observed throwing out in the resident's toilet.</p> <p>Interview with the Employee E13 revealed that she had already given resident one container and a half of Jevity and that the cup of cream-colored liquid that she threw out was the half of the second container of Jevity that she gave to the resident. Further interview with the nurse revealed that the resident only gets one Jevity. Further, Employee E13 confirmed that the order for Resident R14's feeding was only for one Jevity but that Resident R14 complains of being hungry, so she always gives Resident R14 an extra half a container of Jevity.</p> <p>Further interview with Employee E13 revealed that she has been telling the dietician that Resident R14 still complains of being hungry after the one container of Jevity but no changes of the Jevity order has been made.</p> <p>Interview with Dietician Employee E18 conducted on June 12, 2024 at 12:05pm confirmed resident gets Jevity 1.5 237 ml. bolus 6x/day.</p> <p>Further, Employee E18 revealed that she was not aware that the resident requested for more feeding and that she should be made aware if resident requests for more feeding so she can adjust her plan of care. Further, Employee E18 also revealed that resident's caloric intake calculation was based on the current physician's feeding orders. Further Employee E18 also revealed that because we was not aware of the extra Jevity feeding that Resident R14 received, any weight changes in Resident R14 would have been attributed to the current physician's order of Every 4 hours Bolus Feeding: Jevity 1.5 via PEG, 237ml bolus 6x/day, total volume 1422ml per 24 hours and not on the extra Jevity that was given to Resident R14.</p> <p>28 Pa. Code 211.10 (c) Resident care policies</p> <p>(continued on next page)</p>		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(5) Nursing services

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>06525</p> <p>Based on observations of care and services, clinical record review, interviews with staff and reviews of policies and procedures. it was determined that the facility failed to ensure proper treatment and assistive devices to maintain vision for one of two residents reviewed. (Resident R10)</p> <p>Findings include:</p> <p>Review of the undated facility policy titled vision services revealed that it was the responsibility of the staff at the facility to assist each resident with obtaining vision services. The policy also indicated that it was the responsibility of the staff to notify the vision services provider for the necessary vision care services for the residents. The policy indicated that broken or damaged glasses was considered an emergent problem and that the vision service provider would be notified immediately for timely repair services for the resident.</p> <p>Clinical record review revealed a comprehensive quarterly assessment (MDS-an assessment of care needs) dated April 21, 2024 for Resident R10. The assessment indicated that Resident R10 required the use of corrective lenses for adequate vision.</p> <p>Clinical record review revealed that Resident R10 was evaluated on December 12, 2023 and was prescribed corrective lenses by the optometrist.</p> <p>Observations of Resident R10 at 10:30 a.m., on June 12, 2024 revealed that this resident was not wearing glasses. The licensed nurse, Employee E6, reported that the resident had not been wearing his glasses because they were broken. The nurse also reported that that the glasses have been broken since he was in an arguement with another resident in the facility on April 24, 2024.</p> <p>Observations of Resident R10 at 10:35 a.m., on June 12, 2024 revealed that the resident was holding in his hand, a pair of broken eye glasses. Further observations revealed that the frame was cracked and the left lense was missing. The licensed nurse, Employee E6, asked Resident R10 to read a printed Vietnamese picture board. Resident R10 was not able to visualize or read the picture descriptions or captions.</p> <p>Clinical record review revealed that there was no documentation to indicate that the vision service provider was notified, emergently about Resident R10's broken glasses on April 24, 2024.</p> <p>Interview with the licensed practical nurse, Employee E6, at 11:00 a.m., on June 12, 2024 confirmed that Resident R10 had no corrective lenses available for use since April 24, 2024.</p> <p>28 PA. Code 211.5(f)(ii)(iii)(viii)(ix) Medical records</p> <p>28 PA. Code 211.10(a)(b)(c)(d) Resident care policies</p> <p>28 PA. Code 211.12(d)(3)(5) Nursing services</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508</p> <p>Based on observation, clinical record review, staff and resident interviews, it was determined that the facility failed to ensure that a resident who exhibited new onset of decrease in functional abilities receive appropriate treatment and services to improve and prevent further deterioration for one of 28 was observed (Resident R 14).</p> <p>Findings include</p> <p>Observation of Resident R14 conducted during tour of the second-floor unit on May 10, 2024, at 10:42 am revealed that Resident was on his bed. Further, observation revealed that resident was not able to open right hand fully. Further, Resident R14's fingers remain in a in a flexed position when hands were open. interview with Resident R14 conducted at the time of the observation revealed that he doesn't have a splint and that he was not receiving PT (physical Therapy or OT (Occupational therapy) services.</p> <p>Review of resident R14 clinical record revealed that Resident R14 was originally admitted to the facility on [DATE]. Further review of Resident R14's medical record revealed that, on April 6, 2024, Resident R14 was sent to the hospital and was readmitted on [DATE].</p> <p>Further review of Resident R154's clinical record revealed that a significant assessment MDS assessment was conducted on May 7, 2024.</p> <p>Review of Physical Therapy evaluation and plan of treatment dated May 3, 2024, revealed that Resident R14 exhibited new onset of decrease in strength, decrease in functional mobility, decrease in transfer, reduce ability to safely ambulate, reduced balance, reduced functional activity tolerance, decreased postural alignment, reduced static and dynamic balance, increased need for assistance from others and reduced ADL (activity of daily living) participation, indicating the need for physical therapy to assess functional abilities.</p> <p>Further review of Physical Therapy evaluation and plan of treatment dated May 3, 2024, revealed that Resident R14 requires skilled physical therapy services to assess functional abilities, facilitate with all functional mobility, promote safety awareness, enhance rehab potential, increase functional activity tolerance, increase Left Extremity Range of Motion and strength, minimize falls, decrease complaints of pain and teach compensatory adaptation techniques in order to enhance patients quality of life by improving ability to return to prior level of functional skills.</p> <p>Further review of Physical therapy notes revealed no documented evidence that restorative skilled services were provided to Resident R14.</p> <p>Interview with physical therapist Employee E17 conducted on June 12, 2024, at 1:26 pm revealed that Resident R14 was not picked up for restorative physical therapy because Resident R14 was on custodial care.</p> <p>(continued on next page)</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Rehab Director Employee E16 conducted on May 12, 2024, at 2:45 confirmed that resident was not placed on restorative PT because resident was on custodial care and that facility will not get paid for custodial care. Further Rehab director confirmed that Resident R15 can benefit from Restorative Physical Therapy.</p> <p>Further review of Resident R14's clinical record revealed that there was no documented evidence that the resident or the next of kin was informed that Resident R14 was not provided with the needed physical therapy restorative services and the reason for not providing the necessary services. Further there was no documented evidence that the family was given options that can be taken in order for Resident R14 to receive the restorative physical therapy services.</p> <p>Review of resident's clinical document revealed that resident's payor source was keystone community health choice which falls under the umbrella of Medicaid. Further, there was no documented evidence that Resident R14 was custodial care.</p> <p>Interview with business office manager Employee E19 conducted on June 13, 2024, at 11:14 am revealed that Resident R14's payor source was keystone under community health choice which falls under the umbrella of Medicaid.</p> <p>28 Pa. Code 211.10(d)m Resident care policy</p> <p>28 Pa. Code 211.10(b) Resident care plan</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47968</p> <p>Based on clinical review it was determined that the facility failed to monitor labs for one resident on fluid restrictions (Resident R75).</p> <p>Findings include:</p> <p>Review of Resident R75's clinical records revealed the resident was admitted into the facility on [DATE], from the hospital.</p> <p>Resident R75's medical diagnosis include Guillain-Barre Syndrome (rare disorder in which immune system attacks nerves causing weakness, tingling and paralysis, and Myoneural Disorder (a rare autoimmune disorder that affects communication between nerves and muscles), Ataxic Gait (uncoordinated walking), Bipolar Disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs), Disorder of Lung, Osteoarthritis (a type of arthritis that occurs when flexible tissue at the ends of bones wears down, Spondylosis (age-related wear and tear of the spinal disks), Scoliosis (sideways curvature of the spine), Kyphosis (a forward rounding of the back), Anxiety, Ulcerative Colitis (inflamed digestive tract), Hallucinations, and Neuromuscular Dysfunction (disorder that affects the nerves that control voluntary muscles and the nerves that communicate sensory information back to the brain).</p> <p>Review of Resident R75's clinical record including the Minimum Data Set Assessment (assessment completed at specific intervals to determine care needs) dated May 1, 2024, documents Resident R75 has a BIMS score of 13 indicating intact cognition.</p> <p>Review of resident R75's clinical records revealed a hospital discharge summary documenting the resident had developed worsening hyponatremia (a common electrolyte abnormality caused by an excess of total body water when compared to total body sodium content). It was unclear whether it was true or pseudohyponatremia (a rare potentially life threatening condition) from hyperproteinemia (abnormally high levels of protein in blood plasma) from Intravenous immunoglobulin (IVIG- a pooled antibody, and a biological agent used to manage various immunodeficiency states).</p> <p>Review of Resident R75's clinical records revealed physician orders for 1200 ml Fluid restriction daily. Nursing (NSG) to provide 360ml daily, 7-3 shift -200ml, 3-11 shift - 200ml, 11-7 shift- ice chips as needed (PRN) plus 30 ml protein supplement two times a day (BID) 60 ml. Dining to provide 840 ml, 360 ml fluids at breakfast, 240ml at lunch, 240ml at dinner</p> <p>Further review of Resident R75's clinical records failed to reveal evidence that continuation of fluid restrictions was required.</p> <p>Review of Resident R75's clinical records revealed dietary progress notes dated January 24, 2024, at 11:01 a.m., February 29, 2024, at 3:25 p.m., March 29, 2024, at 8:20 p.m., and April 26, 2024, at @:22 p.m., recommending Resident R75's labs be monitored.</p> <p>Review of Resident R75's clinical records revealed no evidence that lab work was done for the resident since admission.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on June 13, 2024, at 2:15 p.m. with Director of Nursing occurred when above information was reviewed and confirmed.</p> <p>28 Pa. Code 211.10(a)(b)(c) Resident care policies</p>

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>46993</p> <p>Based on interview with residents and staff, observations, and review of clinical records it was determined that facility failed to address and/or obtain necessary services for behavioral health care needs for one of 28 residents reviewed (Resident R82)</p> <p>Findings include:</p> <p>Review of Resident R82's clinical record revealed resident was admitted to facility with history of paranoid personality disorder, psychophysiological insomnia and major depressive disorder. Resident has been 302'd [involuntary admission to psychiatric unit] prior to admission for suicidal attempt.</p> <p>Interview with R82 on June 10th, 2024 at 12:30 PM, revealed that the resident has been seeking grief group support due to past trauma of loosing family members/friends. Resident tearful during interview and stated that she does not wish to self-harm, is not interested in pharmacological interventions, and has been asking for non-pharmacological support; specifically, grief support group, which has been helpful in the past because she wants to interact with peers who are able to relate to what she is feeling and is going through.</p> <p>Observations of R82 on June 10th, 2024 at 12:30 PM revealed scars from previous wounds on her abdomen and arms.</p> <p>Review of facility's nurse practitioner's note, employee E12, dated March 11, 2024, states that R82 reports periods of increased depression, she is tearful, had a conversation with her primary care physician (PCP) about attending grief group therapy at hospital. Per R82 report - PCP will be sending consult this month. E12 made nursing aware. R82 struggling with unresolved grief. R82 reports passive death wishes with no plan. looks forward to group therapy. R82 states she is not interested in any medication changes - requesting group grief therapy. Per nursing R82 mostly isolates to her room. Please consult psychology for nonpharmacological interventions to assist with unresolved grief (R82 requesting group grief therapy sessions).</p> <p>Review of nurse practitioner's note, dated March 13, 2024, at 09:00 AM, states R82 was in her room, the room was dark, R82 reported having depressed feelings and suicidal ideation (SI), no plan to follow through. Session focused on her feelings and contributing factors. They are stemming from loneliness, lack of social contact with family/friends and difficulty maintaining relationships .R82 was tearful throughout session, often ruminated over losses and feeling empty.</p> <p>Review of nurse practitioner's note, dated April 1st, 2024, states that R82 continues to express interest in group grief therapy or outpatient treatment and another recommendation made to reach out to psychology for non-pharmacological interventions.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility's social worker's note, E11, dated May 1, 2024, indicates that R82 has poor coping skills, reported increased agitation and several episodes of physical aggression towards other residents, feels depression is getting worse, frequency of intensity of depressive mood has increased. The session focused on receiving higher level of care for therapeutic services. E11 texted unit manager, E4, and discussed current concerns and clinical recommendations.</p> <p>Review of facility's nurse practitioner's documentation, employee E12, dated May 20, 2024, states that resident has a history of agitation and aggression towards others and her wish is to join a group for grief therapy. Should patient become a danger to self or others please call crisis for psychiatric evaluation for an inpatient hospitalization . (Pt. continues to request group grief therapy sessions states been beneficial in the past) please consult psychology for nonpharmacological interventions to assist with unresolved grief.</p> <p>Review of social worker's psychotherapy note, employee E11, dated May 22, 2024, states that her mood was below 1 on a scale of 1 to 10 (10 meaning happy) she was tearful and elaborated more about her feelings R82 reported deflecting her pain by increased self abusive behaviors (upper arms and stomach) The marks were not deep nor did they require medical attention . the session focused on her feelings and self-mutilating behaviors through individual therapy. Discussed the need of higher level of care (i.e. intensive outpatient program or partial program). It is imperative R82 receives higher level of care. She is emotional decompensation and prior history of suicidal attempts. E11 spoke with unit manager, employee E4, after the session, she was informed of the mutilating behaviors and clinical recommendations - E11 sent her a photograph of a doctor at (hospital) who met with R82 about attending group sessions. E11 encouraged E4 to follow up with R82's primary care physician or psychiatrist about submitting paperwork or an extensive outpatient or partial program. E11 will follow up with unit nurse, E4, and provide clinical support as needed.</p> <p>Interview with unit manager, employee E4, on June 11, 2024 revealed that R82 only prefer's a specific facility for outpatient treatment and refuses to explore other options; however, facility unable to provide evidence that attempts were made to provide resident with grief support groups or outpatient treatments provided by alternative facilities.</p> <p>The facility did not provide necessary behavioral health care services to attain highest practicable physical, mental, and psychosocial well-being of resident.</p> <p>28 Pa Code 211.12(d)(1)(5) Nursing services</p>		

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NAME OF PROVIDER OR SUPPLIER Ivy Hill Post Acute Nursing & Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Ivy Hill Road Philadelphia, PA 19150	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>46508</p> <p>Based on review of facility policy, observation, and staff interview it was determined that the facility failed to ensure that all drugs and biologicals are stored and labeled in accordance with professional standards for two of two medication rooms observed (second floor and third floor medication rooms).</p> <p>Findings include:</p> <p>Review of facility Policy on storage of medications revealed that under section Policy Statement, the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Under section Policy Interpretation and Implementation #2. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner.</p> <p>Observation of the second -floor medication room conducted on June 11, 2024, at 11:46 am with licensed nurse Employee E13 revealed that a treatment cart was inside the medication room.</p> <p>Observation of the treatment cart revealed an opened tube of Santyl Collagenase inside the treatment cart. Further, the opened tube of Santyl did not have a label with resident's name attached to it.</p> <p>Interview with licensed nurse confirmed that an open tube of collagenase without any label was inside the treatment cart. Further licensed nurse revealed that it should have been labelled.</p> <p>Observation of the medication refrigerator in the 3rd floor medication room conducted on June 12, 2024, at 9:42 am with Unit manager Employee E14, revealed one opened 5 ml vial of Tuberculin, Purified protein derivative, 5 TU/0.1 ml.</p> <p>Further observation revealed that neither the opened 5 ml vial of Tuberculin, Purified protein derivative, 5 TU/0.1 ml. nor its box had a date opened affixed.</p> <p>Interview with unit manager Employee E14 conducted at the time of the observation confirmed that the neither the opened 5 ml vial of Tuberculin, Purified protein derivative, 5 TU/0.1 ml. nor its box had a date opened affixed.</p> <p>28 Pa. Code 201.18(b)(l) Management</p> <p>28 Pa. Code 211.12(d) Nursing services</p> <p>29 Pa. Code 211.9(i) Pharmacy services</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06525</p> <p>Based on observations of care and services, clinical record reviews, interviews with staff and policy and procedure reviews, it was determined that the facility failed to provide routine dental services from an outside resource to meet the dental needs for one of three residents reviewed. (Resident R36)</p> <p>Findings include:</p> <p>Review of the undated facility policy titled dental services revealed that it was the responsibility of the staff to assist each resident with obtaining routine and emergency dental care. The policy indicated that the facility was responsible for identifying dental needs through assessment and that the resident would receive dental services from an outside provider.</p> <p>Observations of Resident R36 during the noon meal on July 10, 2024 revealed that this resident was refusing to eat his meal. Resident R36 said that the foods did not taste good. It was observed at 12: 30 p.m., on June 10, 2024 on the third floor nursing unit while Resident R36 was speaking, that this resident had obvious or likely cavity or broken teeth. Interview with the nursing assistant, Employee E7, that was familiar with the care of Resident R36 revealed that he would contact the main kitchen for substitute foods (a peanut butter and jelly sandwich); instead of the pork loin which was the main entree served to Resident R36. The sandwich was a softer food item than the pork loin which was harder to chew for Resident R36 with dental care needs.</p> <p>Clinical record review for Resident R36 revealed an admission comprehensive assessment (MDS-an assessment of care needs) dated September 14, 2023 and listed Resident R36 as 69 inches and 124 pounds. A comprehensive quarterly assessment dated [DATE] for resident R36 that indicated this resident weighed 121 pounds. The comprehensive quarterly assessment dated [DATE] for Resident R36 documented a weight of 118 pounds. The weight recorded in the clinical record for Resident R36 for June, 2024 was 116 pounds. The Dietitian assessment dated [DATE] indicated that Resident R36 had a 10.8% weight loss over five months. The resident was recorded as being below usual body weight of 124 pounds and documented as being below ideal body weight of 154 pounds +/- 10%. The dietitian's nutritional care plan was to supplement the diet for Resident R36 with soft foods ice cream, pudding, chocolate milk and a liquid house supplement three times a day.</p> <p>The outside/consulting dental group staff evaluated Resident R36 on March 20, 2024 and indicated that Resident R36 needed full upper dentures. The resident had mild plaque and four teeth that needed extraction. resident R36 was in agreement to proceed with the extractions so that he could have impressions for dentures. On March 25, 2024 the outside dental group again evaluated Resident R36 and indicated that the resident required the four teeth to be extracted due to the fact that Resident R36 had periodontal disease (a serious gum infection that damages the soft tissue and bone supporting the tooth).</p> <p>Interview with the director of nursing, Employee E2 at 10:00 a.m., on June 13, 2024 confirmed that the teeth extractions had not been completed since March, 2024. The director of nursing also confirmed that there was no documentation to indicate a scheduled date for teeth extractions or upper and lower denture fittings for Resident R36.</p> <p>(continued on next page)</p>		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 PA. 211.15 Dental services 28 PA. 211.10(a)(b)(c)(d) Resident care policies 28 PA. 201.14(a) Responsibility of licensee 28 PA. 201.21(c) Use of outside resources

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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>46508</p> <p>Based on observation, it was determined that the facility failed to ensure that proper infection control practices were observed related to tube feeding and medication administration for one of one tube feeding observation and one of five residents observed (R14 and R79).</p> <p>Findings include</p> <p>Observation conducted during tour of the second-floor unit on June 10, 2024, at 9:37 am revealed that licensed nurse Employee E13 was providing Resident R14 with tube feeding via bolus (A way to send formula through the feeding tube using a catheter syringe. Bolus feedings give large doses of formulas several times a day), further observation revealed that Employee E13, licensed staff, was wearing gloves on her right hand but was not wearing gloves on her left hand. Further, Employee E13 was using both hands to handle the feeding equipment, (large syringe, cups)</p> <p>Further observation revealed that the over bed table where the tube feeding equipment and the two cups of cream-colored liquid were placed were dirty and did not have any clean covering.</p> <p>Observation during medication preparation by licensed nurse Employee E15 for Resident R79 conducted on May 12, 2024, at 8:52 am revealed that with gloved hands, Employee E15 placed a small bottle of Cosopt ophthalmic solution for Resident R79 into the medication cup containing Resident 79's po (by mouth-tablets) medications. Employee E15 then removed the small bottle of Cosopt ophthalmic solution and proceeded to administer the po medications to Resident R79 without changing gloves or sanitizing her hands. Further, Employee E15 proceeded to administer Cosopt ophthalmic solution to Resident Powel's left eye without changing her gloves or sanitizing her hands.</p> <p>Further observation revealed that during medication administration for Resident R115. Employee E15 then separated Resident R115's medications into three medication cups, placed the cups on top of the medication cart while preparing the medications, and stacked up the cups on top of each other. Further, the bottom of the two cups were touching the medications under. Employee E 15 then proceeded to enter Resident R115's room and administered the medications to Resident R115.</p> <p>28 Pa. Code 211.12 (d)(1)(5) Nursing services</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>06525</p> <p>Based on observations of the operations within the food and nutrition department, reviews of policies and procedures, interviews with staff, and reviews of the the chemical manufacturers guidelines, it was determined that the facility failed to maintain all mechanical dietary equipment in safe operating condition.</p> <p>Findings include:</p> <p>A review of the facility policy titled dish machine dated June 21, 2023 revealed that the dietary staff were responsible for washing, rinsing and sanitizing all dishes, bowls, cups, mugs, utensils, pots and pans after each meal. According to the policy the dietary staff were to test the chlorine using a test strip to ensure 50 ppm was being dispensed into the machine during the final rinse phase of dish washing.</p> <p>Observations of the dish machine on June 10, 2024 revealed that the low temperature dish machine was not registering (using a chlorine test strip) any chemical sanitizer (hypochlorite) during the final rinse cycle for proper cleaning and sanitizing of the dishes, bowls, cups, mugs, utensils, pots and pans. The chemical was unavailable for use because the mechanical devise and tubing used to dispense the chlorine into the dish machine was not fully functioning.</p> <p>Observations of the three compartment sink operation on June 10, 2024 revealed that dietary staff were unable to test the benzyl ammonium chloride or quaternary ammonium compound sanitizer using the test strip, due to the malfunctioning mechanical device (flex gap) that was connected to the chemical dispenser unit. Further observation revealed that as dietary staff were using the benzyl ammonium chloride sanitizer it caused a white foam on top of the solution and water. Dietary staff were reporting and showing 150 ppm as sufficient concentration of benzyl ammonium chloride sanitizer to effectively clean and sanitize utensils, pots and pans; however a review of the chemical manufacturer's instructions revealed that 200 ppm to 300 ppm of chemical to water ratio was required to clean and sanitize the pots and pans.</p> <p>Interview with the director of dietary services, Employee E3 and dietary aide, Employee E5, at 10:30 a.m., on June 10 and June 11, 2024 confirmed that the dispensing mechanics of the dietary equipment (dish machine and three compartment sinks) were not fully functioning to ensure that dishes, bowls, cups, mugs, utensils, pots and pans were effectively cleaned and sanitized daily after each meal.</p> <p>28 PA. Code 201.18(b)(1)(3) Management</p> <p>28 PA. Code 201.14(a) Responsibility of licensee</p> <p>28 PA. Code 211.10(a)(c)(d) Resident care policies</p>		