STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395535	A. Building B. Wing	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Square Healthcare and Rehabilitation Center	1020 Oak Lane Avenue Philadelphia, PA 19126

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of policy, and interview with staff, it was determined that facility did not develop and implement a baseline care plan for one out of six residents reviewed, related to bladder incontinence (Resident R2) Findings include:Review of facility policy ' Baseline Care Plans, ' revised March 2022, indicates that a baseline plan of care to meet the resident ' s immediate health and safety needs is developed for each resident within forty-eight hours of admission. Review of Resident's R2 clinical record revealed the diagnoses of acute kidney failure with acute cortical necrosis, personal history of malignant neoplasm of prostate, obstructive and reflux uropathy, acute metabolic acidosis, artificial openings of urinary tract. Review of Resident R2's ' skin and wound note completed on August 11, 2025, at 4:00 pm, stated Resident R2 was incontinent with following recommendations: use appropriate moisture barrier creams per formulary to provide thorough skin care with each episode of incontinence. Use formulary briefs when indicated to manage moisture and assess often. While the patient is out of bed using a wheelchair, the use of a chair cushion is recommended. Further review of ' skin and wound ' note stated that due to Resident R2's comorbidities, the resident had an increase risk of skin breakdown - Recommend good hygiene and skin care to prevent skin breakdown. Recommend application of emollient daily. No open wounds on today's skin assessment; please keep patient's skin clean and dry, apply barrier cream as necessary to prevent skin breakdown, and avoid pressure on any bony prominence by adhering to turning protocols and floating heels as applicable. Further review of Resident R2's ' skin and wound ' progress notes dated August 11, 2025 at 10:49 am, states new admission wound rounds conducted with in-house CRNP. The only recommendation is to have resident seen by podiatry for toes nails clipping. All other areas intact. Review of Resident R2's Braden scale for predicting pressure ulcer risk evaluation, completed on September 10, 2025, at 11:03 pm, indicated moderate risk. Further review of Resident R2 ' s clinical record revealed that the resident was hospitalized on [DATE] for surgery to sacral area due to osteomyelitis (infection of the bone). Review of R2's care plan revealed no evidence of goals or interventions related to recommended preventative measure for bladder incontinence. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical records, and interview with residents and staff, it was determined that the facility failed to provide pharmaceutical services to ensure accurate receiving, dispense and administration of medication to meet the needs of a resident according to professional standards of practice relating to medication administration for 1 of 11 residents reviewed (Resident R1) Findings include:Review of the facility's policy titled Administering Medications last revised April 2019 states that medications are administered in a safe and timely manner, and as prescribed. Interview with Resident R1 on November 6, 2025, at 11:45 a.m. revealed that she had complained about her eye being red on October 22, 2025, and that the first time the eye drops were ordered they were lost by the overnight nurse, Employee E6. Then there was an issue getting the eye drops reordered due to a problem with the insurance not paying for the same prescription twice in one week. Resident R1 said that her eye got so bad that it was bright red and that she demanded to go to the emergency room (ER) to have it treated on November 2, 2025. She said that once she started using the eye drops from the hospital her eye was clearing up. Review of Resident R1's clinical record the resident was admitted on [DATE]. An October 22, 2025, progress note revealed that Resident R1 complained of allergies and left eye redness, and that the physician was notified and ordered tobramycin eye drop (an antibiotic treatment used to combat bacterial infections of the eye) four times a day for five days. Review of the electronic medication administration record (eMAR) reveals an October 22, 2025, physician order for tobramycin ophthalmic solution 0.3%, instill one drop in the left eye four times a day for left eye redness for five days starting on October 22, 2025. Further review of the eMAR revealed that each day from October 22, 2025, through November 3, 2025, has an open space, an X or a 9 (med not given see nurse note) all indicating that the resident did not receive the eye drops. Review of the nursing progress notes from October 23, 2025, through October 27, 2025, indicate when a 9 was on the eMAR, a note was written to indicate that the eye drop medication was on order and documented as not given. Interview on November 6, 2025, at 11:30 a.m. with Employee E3, floor nurse who has responsibility for Resident R1's medication administration revealed that there was a problem getting Resident R1's eye drops. That the eye drops were ordered on October 22, 2025, but did not come in until November 3, 2025, but that Resident R1 went to the ER (emergency room) on November 2, 2025, and got eye drops.Interview on November 6, 2025, at 11:35 a.m. with Employee E4, unit manager confirmed that Resident R1's eye drops never came in, and that the resident went to the ER who gave her the same antibiotic eye drops. That Resident R1 saw the eye doctor on November 5, 2025, and another eye drop without the antibiotic were ordered but were still not in yet.Interview with the Administrator on November 6, 2025, at 1:20 p.m. confirmed that there were issues getting Resident R1's eye drops and that after eleven days with no treatment the resident had to go to the ER to get the eye drops. The administrator was not satisfied with the way that the pharmacy handled this situation.28 Pa Code 211.9 (a)Pharmacy Services28 Pa. Code 211.12(d)(1) Nursing Services