STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395537	A. Building B. Wing	08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roosevelt Rehabilitation and Healthcare Center	7800 Bustleton Avenue Philadelphia, PA 19152

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on review of facility policies, clinical record reviews and interviews with staff, it was determined that the facility failed to develop comprehensive person-centered care plans related to a urinary catheter care for one of 9 residents reviewed (Resident R1).Findings include:Review of facility policy, Care Plans, Comprehensive Person-Centered March 2022, revealed, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.Review of Resident R1's clinical record revealed an admission date of August 12, 2024, with diagnoses including chronic kidney disease, urinary tract infection, prostatic hyperplasia with lower urinary tract symptoms, urinary urgency, and urinary retention.A progress note, dated August 8, 2025, stated: Day 1/3 (day of one of three) new Foley catheter 16Fr/10mL placed at urology appointment this morning.A review of the comprehensive care plan dated May 20, 2025, did not reveal a care plan for catheter care.On August 11, 2025, at 11:06 a.m., an interview with the Assistant Director of Nursing, Employee E3, confirmed that no comprehensive care plan had been developed for the urinary catheter.28 Pa Code 211.10(c) Resident care policies28 Pa Code 211.12(d)(5) 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

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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 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. Based upon review of clinical records, interviews with staff and residents and reviews of policies and procedures, it was determined the facility did not ensure residents receive treatment and care in accordance with professional standards of practice, by failing to follow physician's orders for urinary catheter care for 1 of 3 residents reviewed and for the need of 1:1 staff supervision at all times for one of 9 resident reviewed. (Resident R1).Findings include:A review of the policy titled Cather Care, Urinary Policy, last revised dated August 2022 revealed The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. Under documentation stated The following information should be recorded in the resident's medical record: 1. The date and time that catheter care was given. 2. The name and title of the individual(s) giving the catheter care. 3. All assessment data obtained when giving care to catheters. 4. Character of urine such as color (straw-colored, dark, or red), clarity (cloudy, solid particles, or blood), and odor. 5. Any problems noted at the catheter-urethral junction during perineal care such as drainage, redness, bleeding, irritation, crusting, or pain. 6. Any problems or complaints made by the resident related to the procedure. 7. How the resident tolerated the procedure. 8. If the resident refused the procedure, the reason(s) why and the intervention taken. 9. The signature and title of the person recording the data.A comprehensive review of Resident R1's clinical record revealed an admission date of August 12, 2024, with diagnoses including chronic kidney disease, urinary tract infection, prostatic hyperplasia with lower urinary tract symptoms, urinary urgency, and urinary retention.Review of nursing notes, dated August 8, 2025, stated: Day 1/3 (first or three day) new Foley catheter 16Fr/10mL placed at urology appointment this morning. A review of Resident R1's physician orders did not indicate an order for a urinary foley catheter. Continue review of physician orders revealed an order for 1:1 supervision every shift for safety.On August 11, 2025, at 11:06 a.m., an interview with the Unit Manager and the Assistant Director of Nursing (Employee E3) revealed that Resident R1 had a urinary foley catheter in place and was currently out of the facility for a doctor's appointment. However, review of the clinical record showed that a physician's order for the urinary Foley catheter had been missing since August 7, 2025. Employee E3 provided a hard copy of the urology consultation, which outlined that Resident R1 had a urinary foley catheter.On August 11, 2025, at 2:02 p.m. an interview and observation were conducted with Resident R1 in the room, who reported having a foley catheter. At that time, no 1:1 staff were present with Resident R1. At 2:07 p.m., an interview was conducted with the licensed nurse assigned to Resident R1, who confirmed that 1:1 supervision was not in place and contacted Nurse Aide, Employee E7, who was observed sitting at the nursing station. Nurse aide, Employee E7 confirmed she was assigned as the 1:1 staff for Resident R1 but had stepped away from the resident's room for approximately five minutes.On August 11, 2025, at 12:30 p.m. an interview was conducted with the Administrator and Director of Nursing confirming that facility failed to obtain a physician order for a urinary foley catheter order for Resident R1.28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12 (d)(1)(5) Nursing services