

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395558	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER St Monica Center for Rehabilitation & Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2509 South Fourth Street Philadelphia, PA 19148	

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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277</p> <p>Based on review of facility policy, review of clinical records, and staff interview, it was determined that the facility failed to address the potential for developing a pressure ulcer and develop/implement a plan of care to prevent pressure ulcers for one of 34 residents reviewed (Resident R145).</p> <p>Findings Include:</p> <p>Review of undated facility policy Care Planning Protocol revealed nursing provides an overview of medical and nurse care regimes. Nursing provides input especially related to activities of daily living, skin, weights, and safety needs. Care Are Assessment Summary triggers are reviewed by the team to decide whether to proceed with care planning for each triggered area.</p> <p>Review of Resident R145's admission Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated January 25, 2024, revealed the resident was admitted to the facility on [DATE], was cognitively intact, and had a diagnoses of muscle weakness and malnutrition (an imbalance between the nutrients your body needs and the nutrients it gets).</p> <p>Review of Resident R145's MDS dated [DATE], revealed the resident required partial/moderate assistance with rolling left and right (the ability to roll from lying on back to left and right side, and return to lying on back on the bed).</p> <p>Continued review of Resident R145's MDS dated [DATE], revealed the resident was identified as at risk of developing pressure ulcers/injuries (localized injury to the skin and/or underlying tissue as a result of intense and/or prolonged pressure or pressure in combination with shear).</p> <p>Further review of Resident R145's Section V - Care Area Assessment (CAA) Summary within the MDS dated [DATE], revealed Pressure Ulcer/Injury was identified as a triggered care are, which further required a care plan decision.</p> <p>Review of Resident R145's Braden Scale (a validated tool used in healthcare to assess a patient's risk of developing pressure ulcers) assessments dated 01/19/2024, 01/30/2024, and 02/06/2024 identified Resident R145 as at risk for skin breakdown.</p> <p>Review of Resident R145's clinical record revealed no documented evidence the facility developed and implemented a comprehensive person-centered care plan pertaining to the resident's identified risk of pressure ulcer development and further implementing preventative measures.</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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R145's clinical record revealed a skin/wound note dated February 13, 2024, by Licensed Nurse, Employee E5, that indicated the employee was consulted to see Resident R145 for a new intact blister identified on the right heel. Further review revealed Licensed Nurse, Employee E5, recommend pillow boots, offloading heels, and to only wear shoes when working with physical therapy.</p> <p>Review of Resident R45's clinical record revealed the resident was assessed by the Wound Team Physician, Employee E6, on February 14, 2024. Review of the wound consult dated February 14, 2024, by the Wound Care Physician, Employee E6, revealed the area on Resident R145's right heel was assessed as a Stage 2 pressure ulcer (Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer).</p> <p>Interview on September 17, 2024, at 12:23 p.m. with the Director of Nursing, Employee E2, confirmed there was no comprehensive care plan developed for Resident R145 being identified as at risk for skin breakdown.</p> <p>211.10 (d) Resident care policies.</p> <p>211.12 (d)(5) Nursing services.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347</p> <p>Based on facility policy, observation, and staff interviews, it was determined the facility failed to ensure the resident's environment remained free of accidents and hazards relating to medication found at bedside for one of seven residents observed. (Resident R 153)</p> <p>Findings include:</p> <p>Review of facility policy titled Medication Administration Policy revealed licensed nursing professionals will administer medications according to time of administration determined by the facility. Medications administered outside the prescribed time frame requires physician notification and documentation in a medical record.</p> <p>Review of facility policy titled titled Self-Medication Administration Policy revealed that this policy applies to all residents who have been assessed and deemed capable of safely managing their own medications, in accordance with state regulations and nursing home protocols. Documentation of resident's eligibility, training, and ongoing monitoring will be maintained in the resident's medical records.</p> <p>Review of resident physician orders revealed no order or indication that Resident R153 was able to self-administer medication.</p> <p>Review of resident's quarterly minimum data set (MDS -a federally mandated assessment tool) dated July 10, 2024, revealed Resident R153 was admitted into the facility on [DATE], with a diagnosis of dementia (a chronic condition that causes loss of cognitive function such as thinking remembering and reasoning). Further review of Resident R 153's MDS revealed that Resident R153 was determined to have a BIMS (Brief Interview of Mental Status) score of 6. Score of six indicates severe cognitive impairment.</p> <p>Observation of resident's double occupancy room shared with Resident R432 on September 24, 2024, at 1:46 p.m., revealed Resident R153 sleeping in a chair at the end of his bed. A small medication cup containing four pills was observed on Resident R 153's bedside table.</p> <p>Interview with Assistant Director of Nursing, Licensed nurse, Employee E11 at time of above observation confirmed that the cup of medication pills on the bedside table should not have been left there. It is not facility policy to leave medications. Employee E11 is unsure what pills they are and what employee left them.</p> <p>28 Pa. Code 210.20 (a)(1)(6)Staff development</p> <p>28 Pa. Code 211.12 (d)(5) Nursing Services</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39343</p> <p>Based on review of clinical records, observations, interviews with staff and residents, it was determined that the facility failed to ensure the ready availability of necessary emergency supplies for one out of three sampled residents receiving hemodialysis (Resident 141).</p> <p>Findings include:</p> <p>A review of the clinical record revealed that Resident R141 was admitted to the facility on [DATE], with a diagnosis of Dependence on Renal Dialysis.</p> <p>Review of physician order for Resident R141, dated September 25, 2024, indicated a modification of the previous orders for Dialysis as follows: Resident receives dialysis on Tuesday/Thursday/Saturday, one time a day. (Dialysis is a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly).</p> <p>Physician order dated September 19, 2024, for Resident R141, indicated to check Permacath at right chest wall, and to ensure caps are secure and that clamps are closed, Emergency Clamp at bedside. (A Permacath is a special catheter used for short-term dialysis treatment. First a tunnel is created under the skin, then the catheter is placed inside a blood vessel in the neck or just under the collarbone and then threaded into the right side of the heart. The catheter can remain in place up to 12 months).</p> <p>An observation and interview with the Resident R141 on September 27, 2024, at 10:14 a.m., revealed there was no emergency equipment located in the resident room or any Emergency Clamp at bedside. This absence Emergency Clamp at bedside was confirmed with the Unit Manager, a Licensed Nurse, Employee E3, on September 27, 2024, at 10:17 a.m</p> <p>28 Pa Code 211.12(d)(1)(3)(5) Nursing services.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>43277</p> <p>Based on review of facility documentation, review of clinical records, and staff interview. it was determined that the facility failed to develop and implement procedures that assure the accurate acquiring, receiving, dispensing, and administering of medications to meet resident needs for one of 34 residents reviewed (Resident R117).</p> <p>Findings Include:</p> <p>Review of Resident R117's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated June 22, 2024, revealed the resident was cognitively impaired and had a diagnosis of anxiety (a feeling of worry, nervousness, or unease).</p> <p>Review of Resident R117's comprehensive care plan dated October 5, 2022, revealed the resident used anti-anxiety medications related to anxiety disorder. Intervention dated December 8, 2020, included to give anti-anxiety medications as ordered.</p> <p>Review of Resident R117's physician order summary revealed a physician order dated June 17, 2024, to administer two milligrams (mg) of diazepam two times per day for anxiety.</p> <p>Review of Resident R117's medication administration record for September 2024 revealed the 09/14/2024 and 09/15/2024 evening doses of diazepam were coded as 5, which means Hold/See Nurses Note.</p> <p>Review of Resident R117's clinical record revealed no corresponding nurses note as to why the nurse did not administer the diazepam in the evening of 9/14/2024.</p> <p>Continued review of Resident R117's clinical record revealed an order administration note for the diazepam 2mg dated September 15, 2024, at 7:50 p.m. medication not available.</p> <p>Review of Resident R117's clinical record revealed no documented evidence that the physician was made aware of the missed doses, that an alternate treatment was requested, or specific orders for monitoring while the medication was unavailable. Review of the clinical record revealed no documented evidence the licensed nurse determined the reason for unavailability, length of time medication is unavailable, and what efforts were attempted to obtain the medication.</p> <p>Interview on September 27, 2024, at approximately 2:45 p.m. with Regional Support, Employee E7, revealed the facility did not have a written procedure for pharmacy services/unavailability of medications.</p> <p>28 Pa. Code 211.9 (a)(1) Pharmacy services.</p> <p>28 Pa. Code 211.9 (k) Pharmacy services.</p> <p>28 Pa Code 211.12 (d)(5) Nursing Services.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>43277</p> <p>Based on review of facility policy, review of clinical records, and staff interview, it was determined that the facility failed to ensure the attending physician timely reviewed identified irregularities and failed to document the action taken to address the irregularities for two of five residents reviewed (Resident 117 and 144).</p> <p>Findings Include:</p> <p>Review of undated facility policy Consultant Pharmacist revealed the consultant pharmacist will establish a system whereby the consultant pharmacist's observations and recommendations regarding the resident's drug therapy are communicated to the appropriate designee to implement and/or respond to the recommendations in an appropriate and timely fashion. Further review of facility policy revealed the timing of these recommendations should enable a response prior to the next drug regimen review.</p> <p>Review of Resident R117's Consultant Pharmacist Review Physician Report dated February 9, 2024, by consultant pharmacist, Employee E10, revealed the resident's medication olanzapine with Major Depressive Disorder (MDD) diagnosis will trigger for inappropriate antipsychotic use per Centers for Medicaid and Medicare Services (CMS) and to review the diagnosis.</p> <p>Further review revealed the physician did not acknowledge/sign the February 9, 2024, Pharmacist Review Physician Report until April 30, 2024. The physician disagreed with the recommendation and ordered a psych consult for diagnosis for use of the medication.</p> <p>Review of Resident R117's clinical record revealed no documented evidence a psych consult was obtained per the physicians response.</p> <p>Review of Resident R117's Consultant Pharmacist Review Physician Report dated May 18, 2024, revealed the consultant pharmacist, Employee E10, again indicated that the resident's medication olanzapine with MDD diagnosis will trigger for inappropriate antipsychotic use per CMS and to review the diagnosis.</p> <p>Further review revealed the physician did not acknowledge/sign the May 18, 2024, Pharmacist Review Physician Report until August 5, 2024. The physician again ordered a psych consult for diagnosis for use of the medication.</p> <p>Review of Resident R117's clinical record revealed the resident was not assessed by psych until August 7, 2024.</p> <p>Review of Resident R117's Consultant Pharmacist Review Physician Report dated March 9, 2024, by consultant pharmacist, Employee E10, revealed recommendations to consider a gradual dose reduction (GDR) for the medication temazepam.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review revealed the physician did not acknowledge/sign the March 9, 2024, Pharmacist Review Physician Report until May 8, 2024. The physician disagreed with the recommendation and did not document clinical rationale as to why the irregularity was not addressed.</p> <p>Review of Resident R144's Consultant Pharmacist Review Physician Report dated April 30 and May 18, 2024, by consultant pharmacist, Employee E10, revealed recommendations to consider a gradual dose reduction (GDR) for the medication Clonazepam and Klonopin.</p> <p>Further review revealed the physician did not acknowledge/sign the April 30 and May 18, 2024, Pharmacist Review Physician Report until May 8, 2024. The physician disagreed with the recommendation and did not document clinical rationale as to why the irregularity was not addressed.</p> <p>Interview on September 17, 2024, at 12:12 p.m. with Licensed Nurse, Employee E9, revealed this employee started in April 2024 and was catching up on previous pharmacy reviews that were not addressed by the physician.</p> <p>28 Pa. Code 211.9 (a)(1) Pharmacy services.</p> <p>28 Pa Code 211.12 (d)(5) Nursing Services.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>43277</p> <p>Based on review of facility documentation and clinical record review it was determined that the facility failed to ensure documentation for the need for a medication to treat a specific diagnosed condition with use of a psychotropic medication for one of five residents reviewed (Resident R117).</p> <p>Findings Include:</p> <p>Review of Resident R117's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated January 4, 2024, revealed the resident was cognitively impaired and had diagnoses of anxiety and depression.</p> <p>During the monthly medication regimen review, the pharmacist evaluates resident-related information for dose, duration, continued need, and the emergence of adverse consequences for all medications.</p> <p>Review of Resident R117's monthly medication regimen review, dated February 9, 2024, revealed recommendations by the Consultant Pharmacist, Employee E10, that olanzapine (also known as Zyprexa - antipsychotic medication used to treat severe agitation associated with certain mental/mood conditions) with major depressive disorder (MDD) diagnosis will trigger quality indicator for inappropriate antipsychotic use and to further review the diagnosis.</p> <p>Continued review of Resident R117's monthly medication regimen review, dated February 9, 2024, revealed the physician did not acknowledge these recommendations until April 30, 2024. The physician disagreed with these recommendations and ordered a psych consult for diagnosis for this [olanzapine] medication.</p> <p>Review of Resident R117's clinical record revealed a physician order dated August 7, 2024, for 2.5 milligrams of Zyprexa to be given every night for psych consult.</p> <p>Review of Resident R117's entire clinical record revealed no documented specific diagnosed condition for the use of the antipsychotic medication, olanzapine.</p> <p>28 Pa Code 211.12(d)(1) Nursing services</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>39343</p> <p>Based on observations, review of clinical records, and interviews with facility staff, it was determined that the facility failed to ensure that it was free of medication error rate of five percent or greater for two of six residents observed during medication administration (Resident R29, and R151).</p> <p>Findings include:</p> <p>On September 26, 2024, at 9:39 a.m., observed that Employee E13, a Licensed Nurse, administered to Resident R 29, Vitamin D3 10 MCG 400 IU tablet.</p> <p>Review of physician order for Resident R29, revealed an order to administer Vitamin D3 Tablet 25 MCG (1000 UT) (Cholecalciferol), one tablet by mouth in the morning.</p> <p>At the time of the observation, interview with Licensed Nurse, E13, confirmed the above findings.</p> <p>On September 26, 2024, at 9:54 a.m., observed that Employee E14, a Licensed Nurse, administered to Resident R151, the medicine, Metoprolol Succinate ER (Extended Release) Oral Tablet Extended Release 24 Hour 25 MG (Metoprolol Succinate), one tablet by mouth. Employee E14 was going to crush the Extended-Release Tablet, but was timely prevented from crushing the Metoprolol Succinate ER Oral Tablet Extended Release, before administering it.</p> <p>Review of literature indicated that crushing extended-release medicines can result in the administration of a large dose all at once, and can alter the mechanism designed to protect the drug from gastric acids.</p> <p>At the time of the observation, interview with Licensed nurse Employee E14, confirmed the above findings.</p> <p>The facility incurred a medication error rate of 7.41%.</p> <p>Pa Code:211.12(d)(1)(2)(5) Nursing Services.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347</p> <p>Based on review of clinical records and staff interviews, it was determined that the facility failed to ensure two residents were free from significant medication errors for two of three residents reviewed. (Resident R24, and Resident R101)</p> <p>Findings include:</p> <p>Review of resident R 24's annual [NAME] Datra Set (MDS- a federal mandated process for clinical assessments for all residents) dated August 4, 2024, revealed that Resident R24 was readmitted to the facility on [DATE], with diagnoses of seizure disorder and dementia. Resident R 4 was assessed as having a BIMS (Brief Interview of Mental States) score of 5 indicating severely impaired cognition.</p> <p>Review of Resident R24's care plan revealed that Resident R 24 had seizure disorder with a plan to give medications as ordered, monitor and document for effectiveness and side effects.</p> <p>Review of Resident R24's physician orders revealed that Resident 24 had an order for Vimpat (Lacosamide, medication used to treat seizures) oral solution 10 milligram per mill give 15ML by mouth every 12 hours related to seizures ordered August 27, 2024.</p> <p>Review of Resident R24's medication administration report (MAR) revealed that resident had an order for Vimpat oral solution 10 milligram per ml. to give 15ML by mouth every 12 hours related to seizures. Further review of Resident R24's MAR revealed that on the dates of September 23 ,24 , and 25, 2024, the medication was not administer. Continue review of the MAR noted the numeral #5 for the days of September 23, 24, and 25, 2024 instructing to see the nurses' notes.</p> <p>Review of Resident R24's nursing noted dated September 23, 2024, revealed that a new script for Vimpat was needed.</p> <p>Review of Resident R24's nursing notes dated September 24, 2025 and September 25, 2024 revealed no nursing notes on the relating to the resident's medication.</p> <p>Review of nursing progress note dated September 27, 2024 revealed Resident R24 is being monitored for seizure activity due to missed doses of Vimpat. The resident at this time has had no seizure activity alert oriented to person in place. The doctor and Resident 24's family have been notified of the missed medication. The nursing staff were educated on importance and vigilance of medication refill.</p> <p>Review of Resident 101's [NAME] Datra Set, MDS dated [DATE] revealed that Resident 101 was readmitted to the facility April 11, 2024, with diagnosis' including Atrial Fibrillation, hyperlipidemia, and dementia.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R101's physician order revealed an order for a nitroglycerine transdermal patch every 24-hour 0.2 mg. instructed to apply on patch transdermal one time a day for Atrial Fibrulation and remove per schedule.</p> <p>Review of Resident R101's clinical record revealed a nursing note dated June 12, 2024, indicating that there was no patch available.</p> <p>Review of resident Medication Administration record (MAR) revealed resident did not receive the nitroglycerin patch medication on June 12, 2024.</p> <p>Interview with Director of Nursing Employee E2, on September 26, 2024, at 1:35 p.m. confirmed that the medications were not available to administer the residents.</p> <p>28 pa code 211.10 Resident care policies</p> <p>28 pa code 211.12(c) Nursing services</p> <p>28 pa code 211.12(d)(3) Nursing services</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>43277</p> <p>Based on review of facility documentation, review of clinical records, and staff interview, it was determined that the facility failed to obtain laboratory services to meet resident needs for one of 34 residents reviewed (Resident R10).</p> <p>Findings Include:</p> <p>Review of Resident R10's significant change Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated April 2, 2024, revealed the resident had a diagnosis of schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech, and behavior).</p> <p>Review of Resident R10's comprehensive care plan dated July 18, 2024, revealed the resident had potential for episodes of anxiety (a feeling of worry, nervousness, or unease) related to disease process, schizophrenia. Intervention included psychological consultation and treatment as needed.</p> <p>Review of Resident R10's physician order history revealed an order dated April 2, 2024, for Divalproex (also known as Depakote - a medication that contains valproic acid, used to treat manic episodes associated with mood disorder) 500 milligrams (mg) every 12 hours to treat schizoaffective disorder, bipolar type (a form of mental illness that has the features of both schizophrenia and a mood disorder).</p> <p>Review of Resident R10's clinical record revealed a psychiatry progress note dated April 3, 2024, by Psychiatrist, Employee E8, which indicated to continue Depakote as ordered and to check valproic acid levels in two weeks.</p> <p>Review of Resident R10's entire clinical record revealed no documented evidence valproic acid levels were drawn following the psychiatrist's recommendations.</p> <p>Interview on September 26, 2024, at 12:20 p.m. with the Unit Manager, Employee E9, confirmed valproic acid levels were not drawn per the psychiatrists recommendations.</p> <p>28 Pa Code 211.12(d)(1) Nursing services</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395558	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER St Monica Center for Rehabilitation & Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2509 South Fourth Street Philadelphia, PA 19148	
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 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>48347</p> <p>Based on review of facility policy, review of clinical records and interview with staff and residents, it was determined the facility failed to provide dental services in a timely manner for one of eight residents reviewed. (resident R 97)</p> <p>Finding include:</p> <p>Review of facility policy titled Dental Services revealed that the facility will assist residents in obtaining routine care, 24-hour emergency dental care and denture replacement in the case of loss, damage, or ill-fitting dentures. This dental care may be provided in-facility or by scheduling and transporting to a dental provider. In case of an emergency the resident will be transported to a facility that provides emergency dental services.</p> <p>Further review of this policy indicates that any resident identified needing dental services will be referred to the dental provider within 3 days of the identification, and the resident care plan and Kardex will be updated as needed.</p> <p>Interview with Resident R97's family member on September 24, 2024, at 12:20 p.m. revealed that they had concerns relating to a request for dental services since Resident R97 was complaining of dental pain.</p> <p>Review of Resident R97's progress noted revealed a nursing note dated February 18, 2024 stating family wants dentist to see him for tooth pain. management notified.</p> <p>Further review of Resident R97's clinical record revealed residents care conference note dated February 22, 2024, revealed resident 97 and his family are requesting for Resident R97 to see the dentist for tooth pain. Social worker/team added resident R 97 to the dentist list.</p> <p>Review of resident's clinical record indicated the only documented visit from the dentist was June 13, 2024.</p> <p>Request for information regarding this resident's dental history was requested and not provided by the facility.</p> <p>Interview with mobile dentist office (contracted for the facility) receptionist on September 26, 2024 at 12:37 pm, revealed that the resident had only been seen on June 13, 2024.</p> <p>28 Pa. Code 211 .12 (d)(3)Nursing services</p> <p>28 Pa. Code 211.15(a) Dental services</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395558	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER St Monica Center for Rehabilitation & Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2509 South Fourth Street Philadelphia, PA 19148	
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 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>43277</p> <p>Based on observations and staff interview, it was determined that the facility failed to dispose of garbage and refuse properly where food and laundry is received.</p> <p>Findings Include:</p> <p>On September 27, 2024, 11:27 a.m., reviewed the dumpster area in the presence of the Director of Environmental Services, Employee E16 (dumpster is a large trash receptacle designed to be hoisted and emptied into a truck). The dumpster was leaking and oozing creamy colored, foul odorous liquid, through the sides of the dumpster, over the floor, around the dumpster, where the floor was irregularly covered with dark greasy appeared substances. At the time of the finding, E16 confirmed the observation.</p> <p>28 Pa. Code 201.18(b)(3) Management</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395558	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER St Monica Center for Rehabilitation & Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2509 South Fourth Street Philadelphia, PA 19148	

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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>39343</p> <p>Based on observation, review of facility policy and procedure and interviews with staff, it was determined that the facility failed to maintain an effective infection control program related to hand hygiene, appropriate cleaning techniques for medical equipment, for four of the six residents observed during medication administration pass. (Resident 8, Resident 24, Resident 46 and Resident 155)</p> <p>Findings include:</p> <p>Review of Facility policy on Hand Hygiene, and Enhanced Barrier Precautions (EBP), effective date April 1, 2024, indicated that the staff will follow established infection control procedures such as hand washing, antiseptic technique, gloves, and isolation precautions for administration of medications, as applicable. It also indicated that all reusable equipment will be decontaminated and/or sterilized between residents at the point-of-care.</p> <p>On September 25, 2024, 9:24 a.m., during medication administration, to Resident R 155, Employee E15, a Licensed Nurse, used the sphygmomanometer (an instrument for measuring blood pressure), and the pulse oximeter (an electronic device that measures the saturation of oxygen carried in an individual's red blood cells), without disinfecting it, which was used for checking blood pressure, and saturation of oxygen of other residents. At the time of the finding, E15 confirmed the same.</p> <p>On September 25, 2024, 9:39 a.m., during medication administration, to Resident R46, Employee E15, used the sphygmomanometer, and the pulse oximeter, without disinfecting it, which was used for checking blood pressure, and saturation of oxygen of other residents. At the time of the finding, E15 confirmed the same.</p> <p>On September 25, 2024, 9:54 a.m., during medication administration to Resident R8, Employee E14, a Licensed Nurse; after touching the drawer, medication cart, computer, and medication-blister-pack; without disinfecting her hands; picked medication tablet, named Amlodipine Besylate Oral Tablet 10 MG, from the medication-blister-pack; and placed in the medicine- dispensing-cup; with her bare hand. At the time of the finding, E14 confirmed the same.</p> <p>On September 25, 2024, 10:09 a.m., during medication administration to Resident R24, Employee E14; after touching the drawer, medication cart, computer, and medication-blister-pack; without disinfecting her hands; picked medication tablet, named Zonisamide Oral Capsule 100 MG, from the medication-blister-packs; and placed in the medicine- dispensing-cup; with her bare hand. At the time of the finding, E14 confirmed the same.</p> <p>28 Pa Code 211.12 (d)(1)(5) Nursing services</p>