

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395686	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/30/2024
NAME OF PROVIDER OR SUPPLIER West Park Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4401 Haverford Avenue Philadelphia, PA 19104	

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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>41471</p> <p>Based on clinical records, incident/accident reports, staff training records, resident and staff interviews and information submitted by the facility, it was determined that the facility failed to ensure that Resident R1 was free from neglect related to not providing the assistance of two staff during a transfer from bed to chair via mechanical lift. This failure resulted in actual harm for Resident R1 who sustained a fall, a head injury and laceration to the head for one of three residents reviewed. This deficiency was cited as past non-compliance. (Resident R1)</p> <p>Findings include:</p> <p>Review of Resident R1's clinical record revealed the diagnoses of chronic obstructive pulmonary disease (a lung condition cause by damage and inflammation that limits airflow), age related physical debility, morbid (severe) obesity, osteoarthritis of knee (degeneration of joint cartilage), lack of coordination, muscle weakness and history of falling.</p> <p>Review of Resident R1's quarterly Minimum Data Set (MDS- assessment of resident care needs) dated August 2, 2024, revealed that the resident had a BIMS (Brief interview of Mental Status) of 13 which indicated that the resident was cognitively intact. Continued review of the MDS revealed that the resident required substantial/maximal assistance with mobility and was dependent in transfers from bed to chair.</p> <p>Review of care plan for Resident R1 dated October 23, 2023, revealed that Resident R1 was a Hoyer lift transfer with assist of 2 staff.</p> <p>Review of physician order for Resident R1 dated July 30, 2024, revealed an order for transfer via Hoyer lift with 2 person per policy.</p> <p>Review of facility investigation dated September 12, 2024, revealed that Employee E3, Nurse Aide, transferred the resident with a Hoyer lift (mechanical lift) independently. When the resident was in the low position, Employee E3 tried to position the Hoyer pad in the wheelchair. While trying to safely place the resident in her wheelchair by guiding the Hoyer pad, the Hoyer lift tipped to the left side coming into contact with the resident's head causing a laceration and contusion to the left forehead measuring 0.3 X 0.3 cm which was closed using surgical glue. She was transported to the hospital for evaluation and treatment.</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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of statement by Nurse Aide, Employee E3 dated September 12, 2024, confirmed that she was in Resident R1's room using the Hoyer lift without assistance. She stated she did not see any other aide, so she proceeded to use the mechanical lift. She stated she was at the back side of the resident pulling the Hoyer pad, when the resident got close to the chair, the resident fell and hit the side of resident's head.</p> <p>Review of statement by Licensed Practical Nurse, Employee E4, dated September 12, 2024, revealed that she heard Resident R1's roommate calling for help, observed resident halfway in the wheelchair with Hoyer lift on top of her. Blood noted to the left side of the forehead.</p> <p>Review of statement by Nurse Aide, Employee E5, dated September 12, 2024, revealed that Nurse Aide, Employee E3 did not ask for help.</p> <p>Review of statement by Unit Manager, Employee E6, dated September 12, 2024, revealed that Resident R1 stated Nurse Aide, Employee E3 was with her putting her into the chair with the machine. The machine came down on her and the employee and the resident could not get that off.</p> <p>Review of statement by Resident R1 dated September 12, 2024, revealed that the resident stated Nurse Aide, Employee E3 was with her putting her into the chair with the machine. The machine came down on her, her head and the employee and the resident could not get that off.</p> <p>Review of statement by Resident R2 (Resident R1's roommate), dated September 12, 2024, revealed that she heard a noise, sounds like a broken glass. She could not see because the curtain was pulled. She asked the nurse aide in the other side of the room, if she was okay. She stated she heard her roommate yell in pain. Then she yelled for help.</p> <p>Interview with Licensed Practical Nurse, Employee E4 on September 30, 2024, at 10:30 a.m. stated Nurse Aide, Employee E3 on September 12, 2024 did not get any help or get a second person as required to transfer Resident R1 to the wheelchair. Employee E4 stated there was 2 staff required for all Hoyer lift transfer. She stated she saw the resident right after the incident. When she entered the room, the lift was still on the resident. Employee E4 stated it appeared that the legs of the Hoyer lift were not opened enough to prevent the tilting of the lift. When she entered the room the two-metal legs were close to each other. Employee E4 stated if there were 2 staff, it could have been prevented. Employee E4 stated Resident R1 was scared after the incident but she was better now.</p> <p>Interview with Unit Manager, Employee E6 on September 30, 2024, at 10:20 a.m. stated, when she observed the resident, she had a gash on her head. Unit Manager, Employee E6 stated Nurse Aide, Employee E3 did not get any assistance when she used the Hoyer lift. Unit Manager, Employee E6 stated there should be always 2 staff present to do Hoyer transfer.</p> <p>Interview with Resident R1 on September 30, 2024, at 10:40 a.m. stated, Employee E3 used Hoyer lift by herself, and the Hoyer lift fell on top of her. The metal piece of the lift hit her head hard. She stated that caused severe pain, Resident stated the pain was 10 out of a scale of 10. Resident stated she was terrified after the incident. She stated she had some pain after the incident for few days.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of hospital record for Resident R1 dated September 12, 2024, revealed that the resident was evaluated at the emergency room for evaluation of head injury which the resident sustained from Hoyer lift transfer by staff. Resident noted with bleeding to the left side of the scalp, resident complained of mild pain. Resident's scalp injury was treated with surgical glue closure.</p> <p>Interview with the Director of Nursing and Nursing Home Administrator, on September 30, 2024, at 12:00 p. m. stated Nurse Aide, Employee E3 admitted to that she did not ask of help when she used Hoyer lift to transfer Resident R1 which resulted in injury to Resident R1 when the Hoyer lift fell on the resident. Nursing Home Administrator confirmed that facility policy required 2 staff for all Hoyer lift transfers. Nursing Home Administrator confirmed that the injury was sustained by Employee E3 independently transferring Resident R1 using Hoyer lift.</p> <p>This deficiency was identified as actual harm past non-compliance for failure to ensure that Resident R1 was transferred safely via mechanical lift into a chair with the assistance of two staff, resulting in the resident falling and sustaining a head injury.</p> <p>On September 30, 2024, the Nursing Home Administrator presented documentation, indicating that the facility initiated a plan of correction on September 12, 2024, to address the failure of not providing adequate number of staff assistance during a resident transfer from bed to chair via mechanical lift, which resulted in Resident R1 falling from the lift and sustaining a head injury.</p> <p>Facility plan of correction included the following:</p> <p>The facility has terminated the employee for not following the facility protocol for Hoyer lift transfers.</p> <p>Facility conducted audits to ensure all resident who used Hoyer lift has care plan updated.</p> <p>The facility re-educated certified nursing assistants along with competencies on Hoyer lift transfers.</p> <p>The facility will also conduct random observation audits to ensure compliance.</p> <p>All audits will be reviewed during facility monthly QAPI (Quality Assurance Performance Improvement Plan) meetings to ensure compliance with mechanical lift policy.</p> <p>The facility alleged compliance with their plan of correction as of September 26, 2024.</p> <p>Facility education record and competency record verified for completion. Nursing staff was interviewed on September 30, 2024 to verify education of facility policy on mechanical lift. Random resident records reviewed to verify compliance with the facility policy on mechanical lift.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</p>		

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<p>F 0689</p> <p>Level of Harm - 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>41471</p> <p>Based on a review of facility policies, clinical records, incident/accident reports, staff training records, and information submitted by the facility, as well as staff and resident interviews, it was determined that the facility failed to ensure resident environment remained as free of accident hazards and failed to ensure that safe techniques were used during a transfer via mechanical lift. This failure resulted in actual harm for Resident R1 who sustained a head injury and laceration to the head for one of three residents reviewed. This deficiency was cited as past non-compliance. (Resident R1)</p> <p>Findings include:</p> <p>Review of facility policy using a mechanical lift machine dated August 2024, revealed The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. It is not a substitute for manufacturer's training or instructions. 1. At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift. 2. Mechanical lifts may be used for tasks that require:</p> <ul style="list-style-type: none"> a. Lifting a resident from the floor; b. Transferring a resident from bed to chair; c. Lateral transfers; d. Lifting limbs; e. Toileting or bathing; or f. Repositioning. <p>Review of Resident R1's clinical record revealed the diagnoses of chronic obstructive pulmonary disease (a lung condition cause by damage and inflammation that limits airflow), age related physical debility, morbid (severe) obesity, osteoarthritis of knee (degeneration of joint cartilage), lack of coordination, muscle weakness and history of falling.</p> <p>Review of Resident R1's quarterly Minimum Data Set (MDS- assessment of resident care needs) dated August 2, 2024, revealed that the resident had a BIMS (Brief interview of Mental Status) of 13 which indicated that the resident was cognitively intact. Continued review of the MDS revealed that the resident required substantial/maximal assistance with mobility and was dependent in transfers from bed to chair.</p> <p>Review of care plan for Resident R1 dated October 23, 2023, revealed that Resident R1 was a Hoyer lift transfer with assist of 2 staff.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of physician order for Resident R1 dated July 30, 2024, revealed an order for transfer via Hoyer lift with 2 person per policy.</p> <p>Review of facility investigation dated September 12, 2024, revealed that Employee E3, Nurse Aide, transferred the resident with a Hoyer lift (mechanical lift) independently. When the resident was in the low position, Employee E3 tried to position the Hoyer pad in the wheelchair. While trying to safely place the resident in her wheelchair by guiding the Hoyer pad, the Hoyer lift tipped to the left side coming into contact with the resident's head causing a laceration and contusion to the left forehead measuring 0.3 X 0.3 cm which was closed using surgical glue. She was transported to the hospital for evaluation and treatment.</p> <p>Review of statement by Nurse Aide, Employee E3 dated September 12, 2024, revealed she was in Resident R1's room using the Hoyer lift without assistance. She stated she did not see any other aide, so she proceeded to use the lift. She stated she was at the back side of the resident pulling the Hoyer pad, when the resident got close to the chair, the resident fell and hit the side of resident's head.</p> <p>Review of statement by Licensed Practical Nurse, Employee E4, dated September 12, 2024, revealed that she heard Resident R1's roommate calling for help, observed resident halfway in the wheelchair with Hoyer lift on top of her. Blood noted to the left side of the forehead.</p> <p>Review of statement by Nurse Aide, Employee E5, dated September 12, 2024, revealed that Nurse Aide, Employee E3 did not ask for help.</p> <p>Review of statement by Unit Manager, Employee E6, dated September 12, 2024, revealed that Resident R1 stated Nurse Aide, Employee E3 was with her putting her into the chair with the machine. The machine came down on her and the employee and the resident could not get that off.</p> <p>Review of statement by Resident R1 dated September 12, 2024, revealed that the resident stated Nurse Aide, Employee E3 was with her putting her into the chair with the machine. The machine came down on her, her head and the employee and the resident could not get that off.</p> <p>Review of statement by Resident R2 (Resident R1's roommate), dated September 12, 2024, revealed that she heard a noise, sounds like a broken glass. She could not see because the curtain was pulled. She asked the nurse aide in the other side of the room, if she was okay. She stated she heard her roommate yell in pain. Then she yelled for help.</p> <p>Interview with Licensed Practical Nurse, Employee E4 on September 30, 2024, at 10:30 a.m. stated Nurse Aide, Employee E3 on September 12, 2024 did not get any help or get a second person as required to transfer Resident R1 to the wheelchair. Employee E4 stated there was 2 staff required for all Hoyer lift transfer. She stated she saw the resident right after the incident. When she entered the room, the lift was still on the resident. Employee E4 stated it appeared that the legs of the Hoyer lift were not opened enough to prevent the tilting of the lift. When she entered the room the two-metal legs were close to each other. Employee E4 stated if there were 2 staff, it could have been prevented. Employee E4 stated Resident R1 was scared after the incident but she was better now.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Unit Manager, Employee E6 on September 30, 2024, at 10:20 a.m. stated, when she observed the resident, she had a gash on her head. Unit Manager, Employee E6 stated Nurse Aide, Employee E3 did not get any assistance when she used the Hoyer lift. Unit Manager, Employee E6 stated there should be always 2 staff present to do Hoyer transfer.</p> <p>Interview with Resident R1 on September 30, 2024, at 10:40 a.m. stated, Employee E3 used Hoyer lift by herself, and the Hoyer lift fell on top of her. The metal piece of the lift hit her head hard. She stated that caused severe pain, Resident stated the pain was 10 out of a scale of 10. Resident stated she was terrified after the incident. She stated she had some pain after the incident for few days.</p> <p>Observation of the Hoyer lift with Licensed Practical Nurse, Employee E4 on September 30, 2024, revealed that the Hoyer lift was in proper working condition. Employee E4 identified the metal part fell and hit Resident R1's head. A measurement of the metal rod hit which hit the resident's head was measured with the employee. The metal rod measured 2 inch width x 1.25 inch depth and approximately 44 inch long.</p> <p>Review of hospital record for Resident R1 dated September 12, 2024, revealed that the resident was evaluated at the emergency room for evaluation of head injury which the resident sustained from Hoyer lift transfer by staff. Resident noted with bleeding to the left side of the scalp, resident complained of mild pain. Resident's scalp injury was treated with surgical glue closure.</p> <p>Review of psychiatric consult report dated September 19, 2024, revealed that the resident was seen with a recommendation from the facility due to recent incident involving injuries sustained during transfer. The resident had clear recollection of the alleged incident and was able to explain that she was accidentally hit in the forehead with the Hoyer lift during transfer. The resident explained having blood running down the side of her face which was traumatic initially but now confirms she has no depression or anxiety resulting from this incident and reports her pain was addressed immediately from the facility.</p> <p>Interview with the Director of Nursing and Nursing Home Administrator, on September 30, 2024, at 12:00 p. m. stated Nurse Aide, Employee E3 admitted to that she did not ask of help when she used Hoyer lift to transfer Resident R1 which resulted in injury to Resident R1 when the Hoyer lift fell on the resident. Nursing Home Administrator confirmed that facility policy required 2 staff for all Hoyer lift transfers. Nursing Home Administrator confirmed that the injury was sustained by Employee E3 independently transferring Resident R1 using Hoyer lift.</p> <p>This deficiency was identified as actual harm past non-compliance for failure to ensure that Resident R1 was transfer safely via mechanical lift into a chair with the assistance of two staff, resulting in the resident falling and sustaining a head injury.</p> <p>On September 30, 2024, the Nursing Home Administrator presented documentation, indicating that the facility initiated a plan of correction on September 12, 2024, to address the failure of not providing a safe transfer from bed to chair via mechanical lift, which resulted in Resident R1 falling from the lift and sustaining a head injury.</p> <p>The facility plan of correction included the following:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The facility has terminated the employee for not following the facility protocol for Hoyer lift transfers.</p> <p>Facility conducted audits to ensure all resident who used Hoyer lift has care plan updated.</p> <p>The facility re-educated certified nursing assistants along with competencies on Hoyer lift transfers.</p> <p>The facility will also conduct random observation audits to ensure compliance.</p> <p>All audits will be reviewed during facility monthly QAPI (Quality Assurance Performance Improvement Plan) meetings to ensure compliance with mechanical lift policy.</p> <p>The facility alleged compliance with their plan of correction as of September 26, 2024.</p> <p>Facility education record and competency record verified for completion. Nursing staff was interviewed on September 30, 2024 to verify education of facility policy on mechanical lift. Random resident records reviewed to verify compliance with the facility policy on mechanical lift.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</p>		