STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395686	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Park Rehabilitation and Nursing Center	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record and care plan reviews, observations of residents, policy and procedure review and interviews with staff and residents, it was determined that the facility failed to review and revise the residents care plan for three of 28 residents reviewed, in a timely manner, to ensure the greatest benefit to each resident for safety needs, hospice care, and oxygen use Residents (R4, R7, and R28) Findings include: A review of the facility policy titled care plans, comprehensive person-centered dated August 2025 revealed that it was the responsibility of the staff at the facility to develop and implement a care plan to meet the medical, psychosocial, physical and functional needs of each resident. The policy indicated that the care plan interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The policy also indicated that the care plan would include measurable objectives and time frames for the resident to meet their goals and attain or maintain their highest practicable physical, mental and psychosocial well-being. The policy said that the care plan would be revised as information about the resident and the resident's condition changed. Clinical record review for Resident R7 revealed a comprehensive quarterly assessment (MDS -an assessment of care needs) dated November 10, 2025, that indicated this resident was cognitively intact, required staff assistance with toilet hygiene and toilet transfer (staff lifts, holds or supports trunk or limbs). The assessment also indicated that Resident R7 required help from the sitting to the standing position (the staff helps by verbal cues and/or touching and/or contact guard). The assessment indicated that Resident R7 had a diagnosis of age-related osteoporosis, was occasionally in continent of bowel and bladder and had experienced falls since admission to the facility. Observations of Resident R7 at 11:00 a.m., on December 16, 2025, confirmed a diagnosis of osteoporosis (a bone disease making bones weak and brittle with symptoms of height loss and stooped posture). Interview with Resident R7on December 16, 2025, revealed that the resident was reporting delays in staff response time to the activation of her call bell. Clinical record review revealed an unwitnessed fall in the bathroom on November 1, 2025, for Resident R7. The nursing staff documented that Resident R7 was trying to transfer alone, from the wheelchair to the toilet. Clinical record review revealed several falls for Resident R7 from September 2025 through November 2025. (continued on next page)

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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clinical record review revealed that resident R7's care plan had not been updated post fall November 1, 2025. Interview with the director of nursing at 10:00 a.m., on December 18, 2025, confirmed that care planning to prevent falls and promote safety for Resident R7 had not been revised to reflect new strategies/measures to ensure Resident R7 would be free from falls. Review of physician orders for Resident R4 revealed an order for hospice services, dated December 11, 2025. Review of Resident R4's current care plan revealed no care plan problem, goal, or intervention addressing hospice care, comfort treatment, pain management, psychosocial support, or coordination with the hospice agency. Review of Resident R28's clinical record revealed Resident R28 was admitted to the facility on [DATE] with a diagnosis that included acute respiratory failure with hypoxia (insufficient oxygen in the blood), acute pulmonary edema (excessive fluid accumulation in the tissue or air spaces in the lungs), and chronic obstructive pulmonary disease (condition that prevents airflow to the lungs, causing breathing problems). Observation on December 16, 2025 at 10:15 a.m. revealed Resident R28 was receiving 1 liter of oxygen via nasal cannula. Review of Resident R28's physicians order, dated August 31, 2025, revealed continuous oxygen 1 liter per nasal cannula. Review of Resident R28's care plan, revised August 12, 2025, revealed the resident has/at risk for respiratory impairment. Interventions included 5 liters of oxygen via nasal cannula. Interview with Employee E2, Director of Nursing, on December 17, 2025 at 2:00 p.m. confirmed Resident R28's care plan was not revised to reflect current oxygen orders. 28 PA. Code 211.10(a)(b)(c)(d) Resident care policies 28 PA. Code 211.12(c)(1)(3)(5) Nursing services

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility failed to ensure physician orderes were followed for one of six residents reviewed for nutrition (Resident 110).Findings include: Review of physician orders for Resident R110, dated July 24, 2024, revealed that the resident was ordered to receive snacks at 10:00 a.m. and 2:00 p.m. review of the clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including malnutrition (lack of proper nutrition) and abnormal weight loss, and had a BIMS score of 3, indicating severe cognitive impairment. Observation conducted on December 15, 2025, at 9:30 a.m. revealed the resident had a small bag of Cheez-It crackers labeled snack 2/14. Further observations conducted on December 16 and 17, 2025, at 10:00 a.m., 10:30 a.m., 2:00 p.m., and 2:15 p.m. revealed the residents did not receive snacks per physician orders. During follow-up interview conducted with Nurse Aid, Employee E11 on December 12, 2025, at 2:11 p.m. confirmed, I did not give the resident any snacks today. An interview conducted with Nurse Manager, Employee E12, and Nurse Aid Employee E11, conducted on December 17, 2025, at 2:30 p.m. confirmed that the resident did not receive his morning or afternoon snacks. The interview further revealed that providing snacks to residents was the responsibility of the Nurse Aid. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations, interview with resident and staff as well as review of clinical record and review of facility policy, it was determined that facility did not ensure to provide appropriate treatment and services to increase range of motion and/or to prevent further decline for one of 28 residents reviewed (Resident R118)Review of facility policy Resident mobility and range of motion, revised on January 2025, indicates that residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in range of motion (ROM).Further review of policy indicates that residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable.Review of Residents R118 clinical record revealed a medical history of hemiplegia and hemiparesis (weakness and paralysis) following stroke affecting left non-dominant side, need for assistance with personal care.Review of Resident R118's physician orders revealed an active order placed on December 5, 2025, for resident requires left elbow extension splint to be donned for 6 hours daily as tolerated with nursing providing skin checks pre and post donning in order to reduce joint stiffness/contractures.Further review of physician orders revealed an active order placed on December 5, 2025, for resident requires left hand roll splint to be donned for 6 hours daily as tolerated with nursing providing skin checks pre and post donning in order to reduce joint stiffness/contractures.Review of Resident R118's care plan revealed interventions for left elbow extension splint to be donned for 6 hours daily as tolerated with nursing providing skin checks pre and post donning in order to reduce joint stiffness/contractures, and resident requires left hand roll splint to be donned for 6 hours daily as tolerated with nursing providing skin checks pre and post donning in order to reduce joint stiffness/contractures. Observations of Resident R118 on Monday, December 15, 2025, during day shift revealed left elbow and left hand contractures and splint/hand roll in a bin on R118's bedside table.Further observations on Monday, December 15, 2025 as well as on Thursday, December 18, 2025 during day shift, revealed no evidence of applied left elbow splint or left hand roll splint.Interview with Resident R118 on Thursday, December 18, 2025, at 10:30 am, revealed that he has not had sling or hand roll applied in about a week, further elaborating that left elbow splint and hand roll is helpful and he believes nursing staff do not know how to apply the equipment.Review of R118's electronic treatment administration record revealed no evidence of an order placed for left elbow sling application and left-hand roll application.Interview with facility's assistant director of nursing, employee E3, on Thursday, December 18, 2025 at 11:00 am revealed that an order for left elbow sling and left hand roll is inaccurately placed and nursing staff is not able to see the order during treatment administrations.Further interview with E3 revealed that it is not confirmed nursing staff received training on how to apply left elbow sling/hand roll.Findings confirmed with facility's director of nursing on Thursday, December 18, 2025 at 11:10 am.28 Pa Code 211.12(d)(5) Nursing services

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility policy, and staff interview, it was determined that the facility failed to administer pain medication in accordance with physician orders for one of three residents reviewed for pain management (Residents R84). Findings include: Review of facility policy titled Pain Assessment and Management, revised 2025, revealed pain management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals. Clinical record review revealed Resident R84 was admitted to the facility on [DATE] with a diagnosis of hemiplegia and hemiparesis affecting left side (affect movement/sensation on one side of body), chronic obstructive pulmonary disease (condition that prevents airflow to the lungs, causing breathing problems), and pain. Review of Resident R84's physician's order, dated October 07, 2025, revealed an order for Percocet (opioid for moderate to severe pain) 5-325 mg (milligrams) every 6 hours as needed for severe pain 8-10. Review of Resident R84's medication administration record for December 2025 revealed Percocet 5-325 mg was administered for the following pain levels: -December 02, 2025 at 9:37 p.m. pain level of 6. -December 05, 2025 at 6:53 p.m. pain level of 6. -December 06, 2025 at 10:03 p.m. pain level of 5. -December 08, 2025 at 8:01 a.m. pain level of 0. -December 09, 2025 at 10:27 p.m. pain level of 5. Interview on December 18, 2025 at 9:45 a.m. with Director of Nursing, Employee E2, confirmed the facility staff did not administer Resident R84's pain medication according to physician's orders. 28 Pa Code 211.10(c) Resident care policies 28 Pa Code 211.12 (d)(5) Nursing services

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, staff and resident interviews, it was determined that the facility failed to provide culturally competent, trauma care in accordance with professional standards of practice, accounting for the resident's past experiences and preferences in order to eliminate and/or mitigate triggers that may cause re-traumatization of the resident for one of three residents sampled for behavior. (Resident R45)Findings include: Review of Resident R45's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses including schizophrenia (mental health condition that affects how people think, feel, and behave) and epilepsy (neurological disorder). Review of progress note for Resident R45 dated April 24, 2025, revealed that Resident R45 reported a history of sexual abuse and disclosed that the abuse occurred in the past. The note further documented that the resident was abused in the streets and around violence and reported not feeling safe in the streets. Review of Psychology note dated May 1, 2025, revealed that Resident R45 had a history of schizophrenia and post-traumatic stress disorder (PTSD). Review of Care Plan for Reside R45, initiated April 9, 2025, revealed that the resident was care planned for potential to exhibit behaviors that are a result of past trauma(s). The care plan noted a history of sexual trauma while incarcerated; however, the care plan failed to identify resident specific trauma triggers or interventions to mitigate or prevent re-traumatization. Continued review revealed that the facility failed to implement trauma-informed care by not identifying Resident R45's past traumatic experiences and potential triggers, despite documentation of sexual abuse and PTSD, and failed to develop individualized interventions to address those triggers. Interview with the Director of Nursing and Facility Administrator on December 18, 2025, at approximately 11:00 a.m., confirmed the facility failed to identify the residents past traumas experiences and possible triggers that may cause re-traumatization. 28 Pa. Code 211.12(c)(d)(3)(5) Nursing services