

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395704	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Lafayette-Redeemer, The		STREET ADDRESS, CITY, STATE, ZIP CODE 8580 Verree Road Philadelphia, PA 19111	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>47973</p> <p>Based on observations and interviews with staff, it was determined that the facility failed to promote care for residents that maintains or enhances dignity and respect related to dining for one of two dining rooms observed (Second floor dining room).</p> <p>Findings include:</p> <p>Observations of the Seceond floor dining room revealed that Resident R2 was falling asleep at the dining table. Licensed Practical Nurse, Employee E4, shouted across tables, R2, you better wake up or I'll have to come over there and feed you like a baby!</p> <p>Follow-up observations of lunch dining in the second-floor dining room, on April 10, 2024, at 12:00 p.m. revealed the following:</p> <p>A table with four residents seated; one resident was served a meal at 12:00 p.m.; two residents were served at 12:22 p.m.; another resident was served at 12:34 p.m.</p> <p>A table of two residents seated; one resident was served a meal at 12:11 p.m. and the other resident was served at 12:21 p.m.</p> <p>Observations at 12:10 p.m. revealed a nurse aide, Employee E5, was assisting Resident R10 with her meal, while standing up. Interview with Employee E5 confirmed that she should have been seated while feeding the resident.</p> <p>28 Pa. Code 201.29(d) Resident Rights</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 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** 47973</p> <p>Based on review of clinical records, review of facility documentation and interviews with staff, it was determined that the facility failed to ensure that one of 19 was free of accidents related to a transfer into a shower chair. (Resident CL209).</p> <p>Findings include:</p> <p>A review of clinical record for Resident R209 revealed that the resident was admitted to the facility on [DATE], with diagnoses including abnormalities of gait and mobility (deviation from normal walking), muscle weakness, need for assistance with personal care, and history of falling.</p> <p>Review of facility investigation dated, September 29, 2023, revealed that Resident CL209 bumped her leg on the shower chair and sustained a tear to the right lower leg during transfer from bed to shower chair which resulted in 14 stitches.</p> <p>Review of a statement, dated September 29, 2023, by unknown staff, revealed that Resident CL209 was being transferred by two staff: was transferring her with my teammate, I saw blood running down her leg .</p> <p>Further review revealed a statement by a student, dated 9/29, which stated that the two employees were transferring a patient and the patient's foot got stuck under the shower chair. And her foot started to bleed.</p> <p>Further review of staff statements failed to reveal information regarding how the transfer was initiated and performed, by the two nurse aides in order to determined if the resident was transfer from bed to the shower chair safely.</p> <p>Interview with the Nursing Home Administrator, Employee E1, and Director of Nursing, Employee E2, conducted on April 11, 2024, at 12:50 p.m. Employee E1 stated that the reenactment of the incident with the staff took place in the shower room, not in Resident CL209's room, where the original transfer occurred. Further, during interview it was stated that the shower chair was removed from use for safety checks. There was no documentation to confirm that the shower chair was inspected for safety.</p> <p>28 Pa Code 211.10(c) Patient care policies</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>46508</p> <p>Based on and review of facility policy, observation and staff interview, it was determined that the facility failed to ensure that all drugs are biologicals were stored and labeled in accordance with professional standards for one of four medication rooms observed.</p> <p>Findings include:</p> <p>Review of facility policy on drug storage reveal that under the section policy, medications included in the Drug Enforcement Administration classification as controlled substances are subject to special handling, storage, disposal and recording in the facility in accordance with federal, state and other applicable laws and regulations. Under section Procedures, A. the Director of Nursing and collaboration with the consultant pharmacist maintains the facilities compliance with federal and state laws and regulations in the handling of controlled substances. Only authorized license nursing and pharmacy personnel have access to controlled substance. B. Schedule II to IV medications and other medications subject to abuse or diversion are stored in a permanently affixed, double locked compartment separate from all other medications or per state regulation. Alternatively, in a unit dose system, medication may be kept with other medications in the cart if the supply of medication is minimal and the shortage is readily detectable. The access system to the compartment is different from the key that opens the medication cart. If a key system is used the medication nurse on duty maintains possession of the key to control substance storage areas. Backup keys to all medication storage areas, including those for controlled substances, are kept by the director of nursing or designee. C. Controlled substances that require refrigeration are stored within a locked box within the refrigerator. This box must be attached to the inside of the refrigerator.</p> <p>Observation of the second-floor medication room conducted on April 10, 2024, at 10:39 a.m. together with Licensed Nurse, Employee E6 revealed that a narcotic refrigerator was inside the medication room. Further, observation revealed that the narcotic refrigerator had a lock. However further inspection revealed that the refrigerator was not locked and can be opened without the use of a key. Interview with Employee E6 conducted at the time of the observation confirmed that the narcotic refrigerator was inside the medication room was not locked.</p> <p>Observation of the contents of the narcotic refrigerator revealed that a locked plastic see-through narcotic box containing two boxes of Ativan liquid and a dark colored plastic. Further, observation of the narcotic box revealed that it was not affixed to the refrigerator.</p> <p>Inspection of the contents of the narcotic box revealed two boxes of Ativan liquid and a dark colored plastic bag filled with 7 syringes labelled Ativan 0.5 mg/0.5 ml</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Inspection of the contents of the box together with the DON (Director of Nursing) Employee E2 and Employee E6 revealed box#1 labelled with Resident R3's name containing an opened but full vial of 5 ml liquid oral lorazepam 2 mg/ml full, box#2 labelled with Resident R3's name containing an unopened bottle of 5 ml liquid oral Lorazepam 2 mg/ml. Further the narcotic box also contained one dark colored plastic bag labelled with Resident R159's name containing seven prefilled syringes containing Ativan 0.5 ml of liquid. review of labels affixed to the syringes revealed the following: lorazepam 0 .5 mg/0.5 ml.</p> <p>Interview with the DON, Employee E2 conducted at the time of the observation confirmed that the narcotic refrigerator was not locked, further Employee E2 also confirmed that the box containing two bottles of liquid oral Ativan and seven prefilled syringes with 0.5 ml of Ativan was not permanently affixed to the refrigerator. Employee E2 stated that she will immediately have engineering attached the box to the refrigerator.</p> <p>28 Pa. Code 201.18(b)(l) Management</p> <p>28 Pa. Code 211.12(d) Nursing Services</p> <p>28 Pa. Code 211.9 (i) Pharmacy Services</p>		