

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395722	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024
NAME OF PROVIDER OR SUPPLIER University City Rehabilitation and Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 3609 Chestnut Street 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 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>47973</p> <p>Based on review of facility policy, pharmacy documentation, review of clinical records, interview with staff and residents, it was determined that the facility failed to ensure that medications were administered in accordance with professional standards for one of seven residents reviewed. (Resident R7)</p> <p>Findings include:</p> <p>Review of facility policy, titled Administering Medications, revised April 2019, indicated, Medications ordered for a particular resident may not be administered to another resident .</p> <p>Review of physician order for Resident R7 dated June 20, 2023, revealed an order for Diclofenac Sodium 1% Gel to be applied 4 grams to both knees' topically two times a day for knee pain. Further review revealed an updated order, dated January 29, 2024, for Diclofenac Sodium 1% Gel, apply to both knees topically four times a day for knee pain 1 gram per knee 4x daily.</p> <p>Interview with Resident R7 on February 8, 2024, at 10:49 a.m. revealed that staff had been putting someone else's medicine on my legs for a couple of months and that that medicine belonged to another person.</p> <p>Interview conducted with Licensed Practical Nurse, Employee E3, on February 8, 2024, at 10:49 a.m. confirmed that, last Thursday, on February 1, 2024, Resident R7's topical gel medication, stored in Resident R7's bedroom drawer, was labeled with another resident's name. Employee E3 stated, I took it out of his drawer and put the new one in there.</p> <p>Review of pharmacy documentation revealed packing slips dated 7/31/23, 8/31/23, 9/15/23, and 1/27/24. The Diclofenac 1% Gel was dispensed by pharmacy on all four dates as a supply of 200 grams with directions APPLY 4 GRAMS TO BOTH KNEES TOPICALLY BID FOR KNEE PAIN. In every 24-hour period, the directions indicated that a total of 8 grams, 4 grams twice a day, was to be applied. Each dispensed quantity of 200 grams was equivalent to approximately a 25-day supply.</p> <p>Interview with the Pharmacist on February 9, 2024, at 8:57 a.m. confirmed that the facility had not placed a refill order for the months of October, November, and December 2023.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Follow-up interview with the facility Director of Nursing (DON), Employee E2, on February 9, 2024, at 9:45 a. m. confirmed that the facility had not placed a refill order for Resident R7's medication for the months of October, November, and December 2023. The DON stated, most likely, he was getting it somehow; probably another resident went home, and they gave Resident R7 their prescription.</p> <p>28 Pa. Code: 211.9(a)(1) Pharmacy services</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<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>47973</p> <p>Based on observation, staff interviews, and review of facility policy, it was determined that the facility failed to ensure that all drugs and biologicals used in the facility were stored in accordance with professional standards for one of two medication carts observed (second floor cart).</p> <p>Findings include:</p> <p>Review of facility policy, Medication Labeling and Storage, revised February 2023, indicated that compartments containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others.</p> <p>Observation of the second-floor cart with Employee E3, Licensed Practical Nurse, on February 8, 2024, at approximately 10:40 a.m. revealed that the medication cart was missing Resident R7's gel medication, Diclofenac Sodium Topical Gel 1%. Employee E3 proceeded into Resident R7's room and pulled open the residents unlocked right side drawer. Further observations revealed two tubes of Diclofenac Sodium Topical Gel 1% in Resident R7's drawer, unlocked.</p> <p>Interview with the facility Director of Nursing on February 8, 2024, at 12:30 p.m. confirmed that Resident R7's medication should have been in the medication cart locked, and not in Resident R7's side drawer.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code. 211.12(c) Nursing services</p> <p>28 Pa. Code 211.12 (d)(1) Nursing services.</p>		