

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 06/10/2025
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>Based on observations, and staff interviews, it was determined that the facility failed to ensure that a 1 out of 3 residents reviewed was assess for self administration of medications. (Resident R3).</p> <p>Finding include:</p> <p>During an observation in Resident R3's room on May 28, 2025 at 2:30 p.m. a bottle of the above referenced medicated lotion was observed a 2nd time sitting on top of the resident's dresser, and not secured. In addition, a medication cup with 3 white pills were observed on the resident's bedside table. When resident asked if they were left there for him to take, Resident R2 reported, yes, the nurses leave them here for me all the time.</p> <p>During an interview with Employee E7 (licensed nurse) on May 28, 2025 at 2:50 p.m. the licensed nurse confirmed that she provided the resident with his medication in his room, and did not observe him take it. She reported that the three pills that were observed in the resident's medication cup were 2-5 milligram tablets of the medication, baclofen, that is prescribed for chronic pain, and 1-5 milligram tablet of oxycodone that is prescribed to the resident for pain levels.</p> <p>Review of Resident R3's clinical record revealed no evidence that the facility assess the resident to self administer medications.</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, staff interviews and review of facility policy, it was determined that the facility failed to ensure that grievances were investigated and prompt efforts were made to resolve grievances for 1 out of 2 residents reviewed (Resident R1).</p> <p>Findings include:</p> <p>Review of the facility policy, Grievances Complaints, Filings, with a revision date of April 2017 indicated that all grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered, and that actions on such issues will be responded to in writing, including a rationale for the response. The policy also stated that upon receipt of a grievance and/or complaint, the grievance officer or designee will review and investigate the allegations and submit a written report of such findings within five (5) working days of receiving the grievance and/or complaint.</p> <p>Continued review of the policy indicated that the grievance officer and associated department director will review the findings to determine what corrective actions, if any, need to be taken, and that the resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed (verbally and in writing) of the findings of the investigation and the actions that will be taken to correct any identified problems.</p> <p>Review of Resident R1's May 2025 physician orders included the diagnoses of hypertension (high blood pressure); cerebral infarction (a stroke); cognitive communication deficit (difficulty performing activities of daily living safely & efficiently as well as communicating effectively); end stage renal disease (the gradual loss of kidney function reaches and advanced state); dependance on renal dialysis.</p> <p>Review of information reported to the State Survey Agency on May 23, 2025 include a copy of a grievance that was sent by electronic correspondence regarding concern related to Resident R1's care. The grievance was addressed to the Nursing Home Administrator and the Regional Director of Operations for the facility (Employee E3), in addition to others. The electronic correspondence was dated as being sent to the above referenced parties on February 13, 2025 consisted of the following concerns:</p> <p>Dear Authorities of [name of facility] and All Concerned Parties,</p> <p>This email is addressed to all individuals responsible for the care and well-being of my father, [name of resident], particularly the staff at [facility name] and its partner organizations.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On the evening of February 10, 2025, at 9:00 PM, my father called my mother [name of mother] pleading for assistance in getting someone to change him. He reported that he had been requesting to be changed since 7:00 PM, yet no one had responded. When my mother and I arrived at the facility, we spoke with the supervising nurse[name of nurse] who informed us that the second floor has been understaffed for some time. It is important to note that this is not the first time I have heard from both nurses and CNAs (nurse aides) about inadequate staffing levels. This is why, in my last email/grievance to [name of the facility's nursing home administrator]. I specifically inquired about staffing and was assured that the facility had adequate coverage.</p> <p>However, when I asked about the staffing ratio for the evening, Nurse [name] confirmed that only five staff members-three CNAs and two nurses, including herself-were responsible for all patients on the second floor. Additionally, upon our arrival, there was no attending nurse at the second-floor desk, and the front desk phone was not functioning properly. When we attempted to call the facility at [facility phone number], the phone rang continuously without an answer. When I requested that my father be changed, my mother informed Nurse [name] that she had already been calling for over an hour with no response. Nurse [name] then called a CNA named [name], who eventually arrived to assist. At this time, my father stated that he had not been changed since earlier that afternoon. His pajama pants were soiled and soaked through, and feces had spread up his legs. (I have photos and video of the solid depend and pajama pants bagged and given to me by CNA [name]. As we left, Nurse [name] attempted to justify the situation, stating: I am not going to lie. We are understaffed, and it's frustrating. We are doing our best to work as a team to provide care.While I acknowledge her honesty, this is not just a staffing issue-it is a serious matter of safety and quality of care. The conditions my father is enduring are unacceptable, and as I stated to Nurse [name], they pose a direct risk to his health and dignity. This raises several critical concerns that require immediate clarification:</p> <ol style="list-style-type: none"> 1.Is a 5:62 patient-to-staff ratio within state regulations for a skilled nursing facility? 2.Is it within CNA protocol to leave a patient unchanged and unattended for hours? 3.Is it within state regulations to leave a patient unshowered for five days? <p>These ongoing issues must be addressed without delay. At this time, my family is formally submitting another official grievance. We demand a written response that provides a logical, compassionate, and consistent resolution to these serious deficiencies in care.</p> <p>Please provide a clear plan of action detailing how these persistent staffing failures will be resolved. The current conditions do not align with your facility's written mission statement and endanger the well-being of the patients in your care.</p> <p>We expect a prompt response and a concrete resolution.</p> <p>Sincerely,</p> <p>[name of resident's daughter]</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of information submitted to the State Survey agency in February 2025 indicated that on February 10, 2025 at 8:00 p.m. indicated the following: .The facility received a notification from the resident's daughter that on the 3:00-11:00 shift on 2/10, she alleged that her father was left in his soiled diaper for extended period of time. During this time the family has an allegation of neglect. The investigation was found to be unsubstantiated.</p> <p>Review of the facility's grievances from February 2025 through May 28, 2025 did not list the above referenced grievance dated February 10, 2025. No documentation could be found to show evidence that the facility investigated all of the above referenced grievances outline in the February 10, 2025 written correspondence or made any prompt efforts to resolve all of the above the above referenced grievances that was sent to them related to the resident's care.</p> <p>Review of information reported to the State Survey Agency on May 23, 2025 include copies a grievance dated May 6, 2025 that was addressed to the Nursing Home Administrator and the Regional Director of Operations for the facility (Employee E3):</p> <p>Hi [name of Regional Director of Operations] I wanted to bring to your attention another ongoing concern regarding my father's care. Tonight, [name of CNA] was asked at 7:00 PM to assist with changing [name of resident]. He waited until 8:30 PM, but she never arrived. Maybe it was during a shift change, but someone should have assisted him. It appears the call system may not be functioning properly. At 8:30 PM, my father used the call bell again with no response. My mother ultimately called the second-floor nursing station at 9:23 PM, and someone finally came to assist. Unfortunately, this is not an isolated incident. These delays are happening frequently, and despite the recent care plan meeting, there have been no noticeable improvements. Can you please confirm whether the call system is working as expected, and clarify who is supervising the CNAs? We're concerned that basic shift responsibilities are not being met, and it seems patients are not being checked on consistently. I do not want another incident to occur. Thank you for looking into this.</p> <p>Review of the facility's grievances from February 2025 through May 28, 2025 did not list the above referenced grievance dated May 6, 2025. No documentation could be found to show evidence that the facility to investigated the grievance, or made any prompt efforts to resolve the grievances related to the resident's care (e.g. allegation that the resident was not provided with care in a timely manner and a concern that the resident's call bell was not working).</p> <p>During an interview with the resident's daughter on May 28, 2025 at 2:28 p.m. the resident's daughter reported that she still has not received a response from the facility regarding the grievance that she reported in February 2025 or on May 6, 2026 regarding her father's care. She reported that she received, no findings or anything on what went on. The resident's daughter reported I asked for a written response when I wrote the grievance but did not get anything.</p> <p>During an interview on May 28, 2025 at 1:44 p.m. with the Nursing Home and the facility's Regional Director of Operation's (Employee E3) did acknowledge receiving the grievance on February 10, 2025 and May 6, 2026. During the interview the facility could not provide any evidence that all of the concerns documented in the resident's daughter's grievance dated February 10, 2025 and May 6, 2025 were investigated by the facility, and prompt efforts were made to resolve them.</p> <p>28 Pa. Code 201.18 (b)(1)(3)(2.1)(4) Management</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on review of clinical records, facility policy and interview with staff, it was determined that the facility failed to conduct a complete and through investigation for an allegation of potential abuse/neglect for 1 out of 2 residents reviewed (Resident R1).</p> <p>Findings include:</p> <p>Review of the facility policy, Abuse, Neglect, Exploitation or Misappropriation - Reporting, with a revision date of September 2022 indicated that reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations), and are thoroughly investigated by facility management. The policy also stated that the administrator provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation.</p> <p>Review of Resident R1's May 2025 physician orders included the diagnosis of hypertension (high blood pressure); cerebral infarction (a stroke); cognitive communication deficit (difficulty performing activities of daily living safely & efficiently as well as communicating effectively); end stage renal disease (the gradual loss of kidney function reaches an advanced state); dependance on renal dialysis (the process of filtering the blood of a person whose kidneys are not working normally).</p> <p>Review of information reported to the State Survey Agency on May 23, 2025 include a copy of a grievance that was addressed to the Nursing Home Administrator and the Regional Director of Operations for the facility (Employee E3) regarding concerns related to the resident's care. The concern indicated that On the evening of February 10, 2025, at 9:00 p.m. the resident contacted his wife stating that he needed assistance with changed, staff did not respond in a timely manner and that the resident was found to be lying in soiled pajamas that were soaked in urine with feces.</p> <p>Review of the report form investigation of alleged abuse, neglect, misappropriation of property (PB-22) revealed that the investigation regarding the matter was initiated by the facility on February 11, 2025, at 11:00 a.m. and was completed by the facility on February 13, 2025 at 3:00 p.m.</p> <p>Review of the interview the facility conducted with Employee E4 (assigned nurse aide for Resident R1) on February 13, 2025 included the following statement from Employee E4: I checked on [name of resident] at the beginning of the shift asked if he needed anything no. throughout the resident my shift I was checked upon [name of resident] took him his dinner Tray he never complained or ask for anything said he was ok just sleepy and tired. Upon doing my last around his family was on unit and asked for him to be changed. I went ahead and changed [name of resident].</p> <p>Review of the undated interview that the facility conducted with the resident included the following statement: I was given my dinner at 5p.m. by [name of a nursing staff member]. I hit my call light, but nobody came. My dinner was still on my table. My wife and daughter came back up around 9:30 p.m. I was soiled and it went always[sic] through my pants. The big girl with the dreads [name of Employee E4] came and took my tray and changed me about 10 p.m.</p> <p>Review of an undated interview that the facility conducted with Employee E5 (nurse aide) indicated that the resident' daughter and mother came on the unit and the resident was harassing a nurse (Employee E6) .was belligerent and threatening as usually.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an undated interview that the facility conducted with the licensed nurse (Employee E6) who worked the 3:00 p.m. through the 11:00 p.m. on the resident's floor included the following statement I was on the cart for 3-11 and did not see resident' call light on. Some residents did not get changed earlier than usually. However, everyone was taken care of before the end of the shift including [named resident R1].</p> <p>Continued review of the investigation indicated that the facility found that the allegation of neglect was found to be unsubstantiated.</p> <p>Review of the facility's investigation did now provide any evidence that a complete and through investigation was conducted to rule out potential abuse/ neglect. There was no evidence that the facility asked the resident's assigned nurse aide (Employee E5) what time, if any, did she assisted the resident with his toileting needs during her shift that was from 3:00 p.m. through 11:00 p.m. on February 10, 2025.</p> <p>During an interview on May 28, 2025 at 1:44 p.m. with the Nursing Home and the facility's Regional Director of Operation's (Employee E3) the facility could not provide any evidence that the facility asked the assigned nurse aide, if she assisted the resident with his toileting needs and/or assisted the resident with changing his brief at any time during her shift, and if so, when.</p> <p>28 Pa. Code 201.14(a)(e) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1)(3)(e)(1) Management</p> <p>28 Pa. Code 201.29(c) Resident rights</p> <p>28 Pa. Code 211.10(d) Resident care policies</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>Based on staff interviews, review of facility policy and the review of clinical records, it was determined that the facility failed to notify the physician when residents did not receive their hemodialysis treatment from the onsite dialysis center for 2 out of 2 residents reviewed (Resident R1 and Resident R2).</p> <p>Findings include:</p> <p>Review of the facility policy, End Stage Renal Disease dated September 2010 indicated that residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care.</p> <p>Review of Resident R1's May 2025 physician orders included the diagnoses of hypertension (high blood pressure); cerebral infarction (a stroke); cognitive communication deficit (difficulty performing activities of daily living safely & efficiently as well as communicating effectively); end stage renal disease (the gradual loss of kidney function reaches an advanced state) and dependence on renal dialysis (the process of filtering the blood of a person whose kidneys are not working normally).</p> <p>Review of Resident R1's May 2025 physician orders included a physician's order dated May 4, 2024, and monthly thereafter, for the resident to receive dialysis treatment onsite on Monday, Tuesday, Wednesday, Thursday and Friday.</p> <p>Review of information submitted to the State Survey Agency on May 23, 2025 indicated concerns regarding the resident not receiving dialysis treatment on his scheduled days due to the facility's onsite dialysis treatment center having to cancel the treatments due to inadequate staffing in the onsite dialysis center.</p> <p>During an interview on May 28, 2025 at 1:21 p.m. with the Regional Director of Operations (Employee E6) of the facility's onsite dialysis center, Employee E6 reported dates that dialysis services could not be provided due to the following reasons:</p> <ul style="list-style-type: none"> - February 17, 2025, dialysis was cancelled for resident due to a flood on the 1st floor where the onsite dialysis is located. - March 31, 2025, dialysis was canceled due to inadequate staffing in the onsite dialysis center. Dialysis treatments for March 31, 2025 were rescheduled to April 5, 2025. - May 2, 2025, dialysis treatments were cancelled due to in adequate staffing in the onsite dialysis center. Dialysis treatments for May 2, 2025 were rescheduled for residents on May 3, 2025, but that facility's elevator was broken some residents did not get their dialysis treatments on the rescheduled day, May 3, 2025. <p>(continued on next page)</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>Review of Resident R1's nursing notes dated February 17, 2025, at 11:13 a.m. indicated Resident R1 did not attend his scheduled dialysis treatment due to a doctor's appointment that he had scheduled for that day. Resident did not receive dialysis today due to an appointment. Left for appointment via stretcher accompanied by 3 EMT (Emergency Services) drivers @ 0815 (8:15 a.m.). During the above referenced interview with Employee E6, it was also reported that there was a flood in the onsite dialysis center and that treatment was not provided to any resident scheduled for dialysis on the above referenced day.</p> <p>Review of nursing notes did not show evidence that the facility ensured that the physician was notified that the resident did not receive dialysis treatment, as ordered on February 17, 2025 due to the flooding that occurred in the onsite dialysis center.</p> <p>During an interview with the unit manager (Employee E5) on May 28, 2025 at 11:52 a.m. the unit manager confirmed that there was no evidence in the clinical record that the physician was notified of the resident's missed dialysis treatment appointment on February 17, 2025.</p> <p>Review of a nursing note dated March 31, 2025 at 12:57 p.m. indicated that the resident's dialysis treatment for March 31, 2025 would be rescheduled for April 5, 2025 due to inadequate staffing in the onsite dialysis center on March 31, 2025.</p> <p>Review of nursing notes did not show evidence that the physician was notified that the resident did not attend his rescheduled dialysis appointment on April 5, 2025.</p> <p>During an interview with the unit manager on May 28, 2025, at 11:52 a.m. the unit manager (Employee E 5) confirmed that there was no evidence in the clinical record that the physician was notified of the resident's missed his rescheduled dialysis treatment appointment on April 5, 2025.</p> <p>Review of nursing notes on May 2, 2025 at 8:07 a.m. indicated that that resident did not receive dialysis treatment on May 2, 2025. During the above-referenced interview on May 28, 2025 at 1:21 p.m. with the Regional Director of Operations (Employee E6) of the facility's onsite dialysis center, Employee E6 reported that dialysis treatments for May 2, 2025 were cancelled due to inadequate staffing issued, and rescheduled for May 3, 2024</p> <p>Review of nursing notes did not show evidence that the physician was notified that the resident did not attend his rescheduled dialysis appointment on May 2, 2025. Continued review of the nursing notes indicated that the physician was not notified that the resident did not attend his rescheduled dialysis appointment on May 3, 2025.</p> <p>During an interview with the unit manager on May 28, 2025, at 11:52 a.m. the unit manager (Employee E5) confirmed that due to an inoperable elevator on May 3, 2025, residents on the 2nd floor who were rescheduled for dialysis treatment on May 3, 2025 could not attend, due to the 2nd floor elevator not being able to go to the 1st floor, which is where the onsite dialysis center is located. Continued interview with the unit manger revealed that was no evidence in the clinical record that the physician was notified of the resident's missed dialysis treatment appointment on May 2, 2025 or on May 3, 2025.</p> <p>(continued on next page)</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>Review of the resident's dialysis attendance from February 2025 through May 2025 provided by Employee E6 also indicated that the resident also did not attend a dialysis treatment session on February 7, 2025. Review of the resident's nursing notes dated February 7, 2025 at 7:27 p.m. indicated that the resident did not attend dialysis treatment on the referenced date. Continued review of the clinical record did not show evidence that the physician was notified that the resident did not attend this appointment.</p> <p>During an interview with the unit manager on May 28, 2025, at 11:52 a.m. the unit manager confirmed that the clinical record did not show evidence that the physician was notified that the resident did not attend the treatment appointment on February 7, 2025.</p> <p>Review of Resident R2's May 2025 physician orders included the following diagnoses of adult failure to thrive (weight loss, decreased appetite, poor nutrition); cerebral infarction (a stroke); end stage renal disease (the gradual loss of kidney function reaches an advanced state) and dependance on renal dialysis.</p> <p>Review of Resident R2's May 2025 physician orders included a physician's order dated May 7, 2024, and monthly thereafter, for the resident to receive dialysis treatment onsite on Monday, Tuesday, Thursday and Friday.</p> <p>Review of the resident dialysis treatment schedule for Resident R2 provided by Employee E6 indicated that that resident did not receive dialysis treatment on May 2, 2025 due to inadequate nursing staff in the dialysis center. Employee E6 stated that the onsite dialysis center would reschedule the missed May 2, 2025 dialysis appointments to May 3, 2025.</p> <p>Review of nursing notes did not show evidence that the physician was notified that Resident R2 did not attend his rescheduled dialysis appointment on May 2, 2025.</p> <p>Continued review of the nursing notes indicated that the physician was not notified that the resident did not attend his rescheduled dialysis appointment on May 3, 2025.</p> <p>During an interview with the unit manager (Employee E5) on May 28, 2025, at 11:52 a.m. the unit manager confirmed that due to an inoperable elevator on May 3, 2025, residents on the 2nd floor who were scheduled for dialysis treatment located on the 1st floor could not attend, due to the 2nd floor elevator not being able to go to the 1st floor. Continued interview with the unit manger revealed that was no evidence in the clinical record that the physician was notified of the resident's missed dialysis treatment appointment on May 2, 2025, or on May 3, 2025.</p> <p>28 Pa. Code 211.5(f) Medical records</p> <p>28 Pa Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services</p>		

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 06/10/2025
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 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>Based on observations, staff interviews, review of facility policy and the review of clinical records, it was determined that the facility failed to ensure that medications were properly labeled and stored according to professional standards for 1 out of 3 residents reviewed (Resident R3).</p> <p>Findings include:</p> <p>Review of the facility policy, Medication Labeling and Storage with a revision date of February 2023 indicated that the nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner, and that medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Continued review of the policy indicated that each resident's medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.</p> <p>Review of the May 2025 physician orders for Resident R3 included the diagnoses of glaucoma (an eye condition that can lead to vision loss or blindness); chronic obstruction pulmonary disease (COPD-a progressive lung condition that makes it difficult to breath); xerosis cutis (abnormally dry skin); dermatitis (causes swelling and irritation of the skin). Continued review of May 2025 physician orders included a physician's order dated February 26, 2025 for the resident to have the medicated lotion, Amlactin applied to his legs, once a day, for dry skin. Amlactin Daily External Lotion 12 % (Lactic Acid (Ammonium Lactate) Apply to Legs topically one time a day for dry skin.</p> <p>During an observation in Resident R3's room on May 27, 2025 at 1:47 p.m. a bottle of the above referenced medicated lotion was observed sitting on top of the resident's dresser, and not secured. During the observation, it was noted that there was no labeling on the bottle indicating who the medication was prescribed to, as there was no individual's name listed on the medication bottle. The facility Nursing Home Administrator (NHA) , Director of Nursing (DON) were notified of this observation on May 27, 2026 at 3:00 p. m.</p> <p>28 Pa Code 201.18(b)(1) Management</p> <p>28 Pa Code 211.12(d)(1)(2)(5) Nursing services</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>Based on observations and interviews, it was determined that the facility failed to ensure that two of two passengers elevators were in operating condition. (#1 and #2 elevators)</p> <p>Findings include:</p> <p>Review of information reported to the State Survey Agency on May 23, 2025 included a concern regarding the elevators not working properly in the facility since December 2024. Concerns regarding resident's not going to dialysis treatment on the first floor due to an inoperable elevator on May 3, 2025 was also reported in the to the State Survey Agency on May 23, 2025.</p> <p>Review of facility documentation received on June 9, 2025 from the facility regarding the elevators indicated that on December 11, 2024 at 1:24 p.m. someone from the facility reported #2 passenger elevator as being shut down. Continued review of the documentation indicated that on December 12, 2024 elevator technicians arrived at 11:40 a.m. left the elevator out of services, and indicated in the above referenced documentation additional resources required.</p> <p>Review of facility documentation received on June 9, 2025 from the facility regarding the facility elevators indicated that on May 3, 2025 at 5:51 a.m. someone from the facility reported #1 passenger elevator as being shut down. Continued review of the documentation indicated that on May 3, 2025 at 8:36 a.m., elevator technicians arrived at the facility regarding the concern, and checked unit to verify proper and safe operation.</p> <p>During an interview on May 28, 2025 at 1:21 p.m. with the Regional Director of Operations (Employee E6) of the facility's onsite dialysis center, Employee E6 reported that on May 2, 2025, dialysis treatments were cancelled due to inadequate staffing in the onsite dialysis center. Employee E6 reported that dialysis treatments for May 2, 2025 were rescheduled for residents on May 3, 2025, but that facility's elevator was broken, so some residents did not get their dialysis treatments on the rescheduled day, May 3, 2025.</p> <p>During an interview with the unit manager (Employee E5) on May 28, 2025, at 11:52 a.m. the unit manager confirmed that due to an inoperable elevator on May 3, 2025, residents on the 2nd floor who were scheduled for their dialysis treatment make up session could not receive their treatment on May 3, 2025, due to the 2nd floor elevator not being able to go to the 1st floor, which is where the onsite dialysis center is located.</p> <p>During an interview with the Nursing Home Administrator (NHA) on May 27, 2025 at 11:15 a.m. the NHA reported that the #2 passenger elevator has been inoperable for a couple of months. It was clarified with the NHA that the #2 passenger elevator had actually been inoperable since December 2024, was still inoperable, and that it need to be repaired. The NHA reported that the repairs are scheduled to start on June 2, 2025.</p> <p>It was also confirmed during the above referenced interview that resident who resided on the 2nd floor were not able to receive their dialysis treatment on May 3, 2025, due to the inoperable #1 passenger elevator.</p> <p>28 Pa Code 201.14 (a)(c)Responsibility of licensee</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>28 Pa Code 201.18 (b)(1)(3)(e)(1) Management</p> <p>28 Pa 201.29 (a) Resident rights</p>		