STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395722	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University City Rehabilitation and Healthcare Ctr	3609 Chestnut Street Philadelphia, PA 19104

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policies, clinical record review and interviews with staff, it was determined that the facility did not ensure that the medication error rate was less than five percent for two of five residents observed during medication administration (Resident 53 and Resident 110).Findings Include: The facility's medication error rate was 20% based on observation of 25 medication administration opportunities with five errors observed. Review of facility policy, Administering Medications revised April 2019, revealed, Medications are administered in accordance with prescriber orders, including any required time frame. Further review of facility policy indicates Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). Review of Resident R53's clinical records revealed she was admitted to the facility on [DATE] and has diagnoses including hypertension (high blood pressure), anemia (lack of healthy red blood cells in blood), vitamin D insufficiency and hypokalemia (low potassium).Review of Medication Administration Records (MARs) for Resident R53 revealed the following physicians orders:An order for Iron 325 (65 Fe) oral tablet; Original order reads: Give 1 tablet by mouth two times a day for Anemia. Order was scheduled to be administered at 9 AM. Observation on during morning medication pass on January 7, 2026 with Licensed Nurse E8, 2nd Floor Cart 1 nurse, revealed medication was administered at 12:06 PM, which was outside the one hour timeframe indicated in facility policy and over two hours late. An order for Amlodipine besylate 10 mg oral tablet; Original order reads: Give 1 tablet by mouth one time a day for HTN [hypertension]. Order was scheduled to be administered at 9 AM. Observation during morning medication pass with Licensed Nurse E8 revealed medication was administered at 12:06 PM, which was over two hours late.An order for Carvedilol 3.125 MG Oral Tablet [Coreg]; Original order reads: Give 1 tablet by mouth every 12 hours for HTN [hypertension], Hold if SBP (systolic blood pressure) is <100mgHg or HR (heart rate) <60 bpm (DO NOT GIVE MEDS IF SBP LESS THAN 100 OR HR LESS THAN 60). Order was scheduled to be administered at 9 AM. Observation during medication pass with Licensed Nurse E8 revealed medication was administered at 12:06 PM, which was over two hours late.An order for Potassium oral tablet (potassium); Original order reads: Give 20 mEq by mouth two times a day for hypokalemia. Order was scheduled to be administered at 9 AM. Observation during medication pass with Licensed Nurse E8 revealed medication was administered at 12:06 PM, which was over two hours late.An order for Vitamin D3 25 mcg tablet; Original order reads: Give 2 tablet by mouth one time a day for Vitamin D insufficiency. Order was scheduled to be administered at 9 AM. Observation during medication pass with Licensed Nurse E8 revealed medication was administered at 12:06 PM, which was over two hours late. Furthermore, Licensed Nurse E8 almost gave four tablets, believing the order was 100 mcg total, surveyor intervened. Both of these errors were confirmed by Licensed Nurse E8 at the time of the administration.Interview with 2nd floor Unit Manager Employee E11 at 1:15 PM confirmed Licensed Nurse Employee E8 was giving out morning medications scheduled for 9:00 AM at 12:06 PM. Review of clinical records for Resident R110 revealed that resident was admitted to facility with diagnoses including Constipation.Further review of Resident R110's clinical records revealed a physician order, dated December 2, 2025, for Sennosides 8.6 mg tablet (oral) sennosides, to be (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered in the morning and at bedtime for constipation, scheduled for 9:00 AM and 9:00 PM.Observation conducted at 9:10 AM on January 7, 2026 revealed Licensed Nurse E7 administered to Resident R110 Senna-Plus (docusate sodium-sennosides 50mg-8.6 mg) due to the originally prescribed medication being out of stock. Further observation revealed Resident R110 refused this medication. 28 Pa. Code 211.9(a)(1) Pharmacy services28 Pa. Code 211.12 (d)(5) Nursing services

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of facility documentation, review of clinical records, and staff interview it was determined that the facility failed to notify the Office of the State Long-Term Care Ombudsman of facility-initiated emergency transfers to the hospital for one of two residents reviewed for hospitalizations (Resident R10). Findings Include: Review of Resident R10's clinical record revealed a nursing note dated November 10, 2025, which indicated that the resident had a change in condition and was ordered by the physician to be transferred to a local hospital for evaluation. Review of Resident R10's clinical record revealed no documented evidence that the Office of the State Long-Term Care Ombudsman was notified of the facility-initiated emergency transfer. Interview on January 9, 2026, at 11:54 a.m. with Employee E1, Nursing Home Administrator, confirmed that the Office of the State Long-Term Care Ombudsman was not notified of facility-initiated emergency transfers for October and November 2025 Further, interview on January 9, 2026, at 12:05 p.m. with the Administrator, confirmed that the Long-Term Care Ombudsman has not been notified of facility-initiated emergency transfers and discharges since October 21, 2025, when the list of these transfers and discharges was sent for the month of September 2025. He further indicated that they had hired a new Social Worker and that this requirement had not been communicated to her, and that they sent out the notice for December 2025 transfers and discharges on January 9, 2026. 28 Pa. Code 201.14(a) Responsibility of licensee

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on clinical record review, observation, and staff interviews, it was determined the facility did not provide services in accordance with accepted professional standards of quality related to daily weights for one of 26 clinical records reviewed (R19).Findings Include: Record review of Resident 19's medical record revealed a physician order for daily weights for cardiac monitoring with active dates 12/15/2025 through 1/12/2026. Cardiac documentation stated: [R19] was seen on cardiac rounds today. She was coughing, crackles to lower base with rhonchi. Jugular vein slightly distended. [R19's] diuretic dose was changed. CXR ordered. BNP ordered. Changes discussed with resident. UM to put resident on report so that staff can monitor patient and maintain her daily weights. On January 8, 2026, at 10:23 AM, an interview with Resident 19 revealed she had not been weighed, despite an active daily weight order. Record review of the MAR and EMR on January 8, 2026, at 10:39 AM showed weight entries that had been documented and initialed, although no weights were taken. Multiple daily weight entries were missing for the review period.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical records, observations, and staff interview it was determined that the facility failed to maintain personal care needs for dependent residents for two of 26 residents reviewed (Resident R68 and R10).Findings Include: Findings Include:Review of facility policy Activities of Daily Living (ADL), Supporting revealed appropriate care and services are provided for residents who are unable to carry out ADLs independently, to include hygiene (bathing, dressing, grooming, and oral care).Review of Resident R68's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated December 10, 2025, revealed the resident had impairment in functional limitation in range of motion in the upper and lower extremity and required set-up assistance with personal hygiene.Further review of Resident R68's MDS revealed the resident was assessed with moderate cognitive impairment and had diagnoses of cerebrovascular accident (CVA - a sudden interruption of blood flow to the brain), hemiplegia (one sided body paralysis) affecting right dominant side, malnutrition (when the body does not get the right amount of nutrients).Review of Resident R68's comprehensive care plan dated October 25, 2024, revealed the resident had an ADL self-care performance deficit and was dependent on staff for grooming/personal hygiene. Intervention dated December 4, 2025, revealed to check nail length and clean on bath day and as necessary.Observations on January 7, 2026, at 10:15 a.m. revealed Resident R68 had a right-hand contracture (a shortening and stiffening of muscles that limits joint movement). Resident R68's right hand was observed to lay naturally in a fist. Further observations on January 7, 2026, at 10:15 a.m. revealed the fingernails on Resident R68's right hand were long, folding into the palm of his/her hand. Resident R68 confirmed wanting the nails trimmed.Review of Resident R10's comprehensive MDS dated [DATE], revealed the resident had impairment in functional limitation in range of motion in the upper and lower extremity and was dependent on staff with personal hygiene.Further review of Resident R10's MDS revealed the resident was assessed with severe cognitive impairment and had diagnoses of arthritis (joint inflammation), aphasia (communication deficits), CVA, and hemiplegia or hemiparesis (one sided muscle weakness).Review of Resident R10's comprehensive care plan dated May 14, 2021, revealed the resident had an ADL self-care performance deficit and required assistance for grooming/personal hygiene. Intervention dated November 5, 2021, revealed to check nail length and clean on bath day and as necessary.Observations on January 8, 2026, at 12:15 p.m. revealed Resident R10 had a right-hand contracture. Resident R68's right hand was observed to lay naturally in a fist. On January 8, 2026, at 12:15 p.m. with the assistance of Licensed Nurse, Employee E11, he/she opened Resident R10's right hand to find the resident's long, thick, and dirty beneath the nail. Licensed Nurse, Employee E11, confirmed Resident R10's nails required care.28 Pa. Code 211.12 (d)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, review of clinical records, observations, and staff interviews it was determined that the facility failed to provide treatment/services for a resident with limited mobility/range of motion to increase range of motion and/or to prevent further decrease for one of 4 residents reviewed (Resident R10). Review of Resident R10's comprehensive Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated November 17, 2025, revealed the resident was assessed with severe cognitive impairment and had diagnoses of arthritis (joint inflammation), aphasia (communication deficits), and hemiplegia (one sided paralysis) or hemiparesis (one sided muscle weakness).Continued review of Resident R10's comprehensive MDS dated [DATE], revealed the resident had impairment in functional limitation in range of motion in the upper and lower extremity and was dependent on staff with personal hygiene.Review of Resident R10's comprehensive care plan dated May 13, 2024, revealed Resident R10 had right side weakness and right-hand contracture (a shortening and stiffening of muscles that limits joint movement).Further review of Resident R10's comprehensive care plan revealed interventions dated November 20, 2025, for passive range of motion (somebody or something else, such as a therapist or machine, is moving a body part or a joint) to the right upper extremity, and active range of motion (how far a person can move a joint themselves) to the left upper extremity.Observations on January 8, 2026, at 12:15 p.m. confirmed Resident R10 had a right-hand contracture. Resident R10's right hand was observed to lay naturally in a fist. Resident R10 was unable to open the right hand by him/herself. Continued observations on January 8, 2026, at 12:15 p.m. revealed Licensed Nurse, Employee E11, needed to physically help Resident R10 open his/her hand.Review of Therapy to Restorative Nursing Communication documentation dated February 18, 2025, revealed that occupational therapy recommended passive range of motion to the right upper extremity and active range of motion to the left upper extremity.Interview on January 8, 2026, at 12:45 p.m. with the Director of Rehabilitation, Employee E15, revealed restorative nursing recommendations were intended to be completed daily with nursing staff. Review of Resident R10's clinical record revealed the active and passive range of motion recommended by therapy was only documented as completed three times from 12/20/2025 through 01/07/2026. 28 Pa. Code 211.12 (d)(5) Nursing services.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interviews and the review of clinical records, it was determined that the facility failed to maintain complete and accurate records related to dialysis communication for one of three Dialysis-Residents reviewed (Residents R32).Findings include:Review of Resident 32's clinical records indicated that R32 was admitted in the facility on November 18, 2025, with Diagnoses including End Stage Renal Disease (the final stage of Chronic Kidney Disease -CKD-, where kidneys fail, requiring dialysis or a kidney transplant for survival, as they can no longer filter waste effectively). Review of physician order, dated November 19, 2025, revealed; R32 receives Dialysis Treatment on Mondays, Tuesdays, Wednesdays, Thursdays, and Fridays. It also included an order to Check Dialysis Communication form, upon return from Dialysis; Vital Signs upon return; one time a day every Mondays, Tuesdays, Wednesdays, Thursdays, and Fridays.Review of Resident R32 's Hemodialysis Communication Record revealed that it lacked the following information as required per the communication log:On December 30, 2025; the Section to be completed by Dialysis Unit and Returned with Resident such as Pre Dialysis Weight, Post Dialysis Weight, Estimated Dry Weight, Total Fluid Removed, Post Treatment Vitals, Among Fluid Consumed During Dialysis, Medications Given During Dialysis, and Issues During Treatment.On December 30, 2025; December 24, 2025; December 16, 2025; December 15, 2025; December 12, 2025; and December 10, 2025; the Section to be completed upon return following Dialysis, such as AVG/AVF (AVG -Arteriovenous Graft- and AVF-Arteriovenous Fistula- are surgical connections for hemodialysis, with an AVF being a direct joining of an individual's own artery to a vein : the preferred, longer-lasting option, and an AVG using a synthetic tube to connect them when veins are inadequate. Both create high-flow access for needles, but AVFs are best for durability, while AVGs are used when fistulas fail or can't mature, though AVGs have higher infection/clot risks), Bruit/Thrill Present (In dialysis, the bruit-a whooshing sound- and thrill -a buzzing vibration- are crucial signs of a healthy arteriovenous (AV) fistula, indicating good blood flow; care givers check these daily with a stethoscope and fingertips, and a loss of either can signal a dangerous clot or blockage, requiring immediate medical attention); Catheter Dressing Dry/Intact; Signs/Symptoms Of Infection; and Additional Comments.Interview with the Charge Nurse, a Licensed Nurse, Employee E13, on January 8, 2026, at 11:22 a.m., confirmed lack of information in the Hemodialysis Communication Record of R32.28 Pa Code 211.5(f) Clinical records

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations, review of facility policies and interviews with staff, it was determined that the facility failed to ensure that medications were stored in accordance with currently accepted professional principles for one of three medication carts reviewed (second floor front cart/cart 1).Findings Include:Review of facility policy, Medication Labeling and Storage, revealed that Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. Further review of facility policy indicates that, 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Additionally, policy states, 4. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) 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. 5. Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. 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.Observation conducted on January 7, 2026, at approximately 12:06 PM of Employee E8, Licensed Nurse for 2nd Floor Cart 1 (front cart), revealed three distinct cups of unidentified medications in individual medicine cups sitting in the top drawer of her cart.Interview with Employee E8 at the time of this observation confirmed that these cups were for residents for whom she had attempted to administer medications, but the residents were otherwise unavailable, so she stored the pre-poured cups containing medicine pills in the top drawer to reattempt administration at a later time. Further interview with Employee E8 revealed she was aware this was not in compliance with the facility's medication administration/storage policy.Observations during Employee E8's morning medication pass, which was at the same time or 12:06 PM and later, revealed at least two instances wherein the nurse walked away from the cart to enter a resident's room without having locked her medication cart.Interview with Employee E8 during this time revealed her statement, I guess I should not have done that [walked away from an unlocked cart] in front of you.28 Pa Code 561.13 Storage28 Pa Code 561.15 Locked storage

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on clinical record review, observation, and interview, the facility failed to ensure timely follow-up and provision of recommended dental services for a resident with an identified dental need for one of 26 residents reviewed (Resident R95).Findings include: Review of Resident R95s clinical records indicated that R95 was admitted in the facility on February 27,2020 with Diagnoses included but not limited to Unspecified Convulsions: (Seizure activity), Essential Hypertension: (High blood pressure) Type 2 Diabetes:(High blood sugar).Interview with the resident on January 6, 2026, at 10:34 am revealed complaints regarding not having dentures and lack of follow-up after the dental appointment. Interview with the resident's representative on January 6, 2026, at 10:36 am confirmed the resident's concerns that dentures had been recommended but not provided and stated she had not been informed of any progress or next steps regarding denture services. Observations during the survey, the resident R95 was observed eating meals without teeth or dentures.Review of the resident R95 dental record on January 7, 2026, revealed the resident had a routine dental appointment on 9/2/2025. Dental documentation indicated the resident was edentulous and the dentist recommended full upper and full lower dentures.Further review of the medical record showed no documentation of denture impressions, fittings, delivery, or scheduling of follow-up dental appointments after the recommendation was made. There was no evidence of a care plan addressing the resident's dental needs following the dental visit. There was no documentation of resident's refusal of services. Additional record review revealed that procedure authorization was not initiated until January 9, 2026, approximately four months after the dental recommendation. No documentation was found explaining the delay or demonstrating interim efforts by the facility to obtain the recommended dentures. 28 Pa. Code S 211.12(d)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policies, review of facility documentation, clinical record review and interviews with staff, it was determined that the facility failed to maintain an effective infection control program related to medication administration (Residents R110, R117, R49 and R53) and Enhanced Barrier Precautions for two of 10 residents reviewed (R32, R49). Findings include: Review of facility policy titled, Administering Medications, revised April 2019, revealed 25. Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. An observation of medication pass with Employee E7, Licensed Nurse on 1st Floor Cart 1, on January 7, 2026 at approximately 9:27 AM, on the first floor nursing unit revealed an open employee [NAME] energy drink can, the opening covered by an empty medicine cup, while administering medications to Residents R110 (9:10 AM), R117 (9:36 AM) and R49 (9:51 AM). Further observation of medication pass of Employee E7, Licensed Nurse on the first floor nursing unit revealed that Employee E7 touched the medication pills with his fingers as he popped them out of the medication cards for Residents R110, R117 and R49. This finding was discussed with the Director of Nursing, Employee E2, and the Assistant Director of Nursing/Infection Preventionist, Employee E9, upon Exit Conference on January 9, 2026 around 1:15 PM. An observation of medication pass with Employee E8, Licensed Nurse on 2nd Floor Cart 1, on January 7, 2026 around 12:06 PM on the second floor nursing unit revealed that she touched the medication pills with her fingers as she popped them out of the medication cards for Resident R53. When the above was confirmed during interview with Employee E8, Licensed Nurse revealed in her statement: It is difficult not to touch the medications while popping them out with these (artificial nails). This finding was discussed with the Director of Nursing, Employee E2, and the Assistant Director of Nursing/Infection Preventionist, Employee E9, upon Exit Conference on January 9, 2026 around 1:15 PM. Further observation of Employee E8, Licensed Nurse on 2nd Floor Cart 1, on January 7, 2026 around 12:06 PM revealed she brought a small zippered bag into the room with her containing her vital sign equipment (Blood pressure cuff, etc.) to take the vital signs of Resident R53 just prior to medication administration. She was not observed sanitizing the bag or its contents after use on Resident R53. Interview with Employee E8 at this same time revealed she keeps her vital sign equipment in this bag and brings it into each resident's room for whom she has to administer medications in order to take residents' vital signs at the time of their medication administration. Review of Policy Statement of the facility about Enhanced Barrier Precautions (EBP), revised in April 2025, indicated that Enhanced Barrier Precautions are utilized to prevent the spread of Multi-Drug-Resistant Organisms (MDROs) to residents. Enhanced Barrier Precautions require the use (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of targeted personal protective equipment (PPE) during high contact patient/resident activities. Review of Resident R32 's clinical record revealed that the resident was admitted to the facility on [DATE]. Diagnoses included Pressure Ulcer of Right Heel, and Pressure Ulcer of Left Heel. Review of physician order dated November 26, 2025, for R32, indicated an order stating, Cleanse bilateral heel with Normal Saline Solution (NSS), apply Santyl, cover with bordered dressing, one time a day for Wound Care and as needed for Soilage/ Dislodgement. Review of physician order dated November 20, 2025, for R32, indicated an order stating: Enhanced Barrier Precautions, every shift for dialysis access/wound. On January 7, 2026, at 10:42 a.m., observed wound treatment administered by a License Nurse, Employee E13, the nurse did follow physician order for bilateral heel, except for the Enhanced Barrier Procedure. E13 did not use proper Personal Protective Equipment (PPE) including targeted gown as directed in the Enhanced Barrier Precaution Policy of the Facility. At the time of the finding, the same was confirmed with E13, and Nursing Supervisor, E14. Review of Resident R49 's clinical record revealed that the resident was admitted to the facility on [DATE]. Diagnoses included Pressure-Induced Deep Tissue Damage of Sacral Region. Review of physician order dated December 19, 2025, for R49, indicated an order stating, Sacrum: Cleanse with NSS, apply Medi Honey, NSS moistened gauze, cover with Silicone Super Absorbent dressing; one time a day for Wound Care, AND as needed for Soilage/ Dislodgement. On January 8, 2026, at 10:48 a.m., observed wound treatment administered by a License Nurse, Employee E13. The nurse did follow physician order for Sacral Wound, except for the Enhanced Barrier Precaution Procedure. After the wound treatment, Employee E13 could not discard the used gown in a protective bag, but carried the used gown exposed, outside the resident room, and placed in an open trash box attached with the treatment cart. At the time of the finding, the same was confirmed with E13. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(d) Management