

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395738	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Paul's Run		STREET ADDRESS, CITY, STATE, ZIP CODE 9896 Bustleton Avenue Philadelphia, PA 19115	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>43277</p> <p>Based on review of facility documentation, clinical record reviews, and interviews with staff, it was determined that the facility failed to notify the Office of the State Long-Term Care Ombudsman of facility-initiated emergency transfers as required for one of two records reviewed for hospitalization s (Residents R111).</p> <p>Findings include:</p> <p>Review of progress notes for Resident R111 revealed a note, dated July 20, 2024, at 3:48 p.m., which indicated that the resident had abdominal pain, nausea, and vomiting and was subsequently transferred to a local hospital emergency department for evaluation.</p> <p>Further review revealed that there was no indication that the Office of the State Long-Term Care Ombudsman was notified of Resident R111's facility-initiated emergency transfer to the hospital.</p> <p>Interview on October 18, 2024, at 1:25 p.m. with Social Services, Employee E10, confirmed that the Office of the State Long-Term Care Ombudsman was not notified of Resident R111's facility-initiated emergency transfer to the hospital.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(2) Management</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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51165</p> <p>Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to develop a baseline care plan that included the information necessary to properly care for a resident within 48 hours of admission for two of 24 residents reviewed. (Resident R69)</p> <p>Findings include:</p> <p>Facility policy titled Baseline Care Plan (2024), indicated that This facility will develop an initial person-centered care plan within the first forty-eight (48) hours of admission for every resident. The Baseline Care Plan will provide instructions for care of the resident. Completion and implementation of the Baseline Care Plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among all facility staff members, increase resident safety and safeguard against adverse events that are most likely to occur in the immediate days after admission prior to development of the Comprehensive Care Plan and to ensure the resident and representative are informed of the initial plan for delivery of care and services by receiving a written summary of the Baseline Care Plan or a copy of the Baseline Care Plan.</p> <p>Review of Resident R69's clinical record revealed Resident R69 was admitted to the facility on [DATE] with a diagnosis of aftercare following joint replacement surgery, major depressive disorder, urinary tract infection, and Type 2 diabetes (condition that affects how the body uses sugar as a fuel).</p> <p>Review of Resident R69's clinical record revealed Resident R69 had a care plan initiated September 23, 2024. The baseline care plan only included one focus area, which was resident will transition to long term care after rehab. Resident R69 did not have a completed baseline care plan until September 26, 2024, which is after Resident R69's 48 hours of admission.</p> <p>Review of Resident R315's clinical record revealed Resident R315 was admitted to the facility on [DATE] with a diagnosis of heart failure (condition where the heart cannot pump as well as it should), dysphagia (difficulty swallowing), and hypertension (high blood pressure).</p> <p>Review of Resident R315's clinical record revealed Resident R315 had a care plan initiated October 7, 2024. Resident R315's baseline care plan did not include the minimum healthcare information necessary to properly care for Resident R315 until after 48 hours of Resident R315's admission.</p> <p>Interview on September 17, 2024 at 11:40 a.m with Employee E7, Licensed Practical Nurse, confirmed Resident R69 and Resident R315 did not have a their baseline care plans completed within 48 hours of admission.</p> <p>28 Pa. Code 211.10(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277</p> <p>Based on review of facility policy, review of clinical record, and staff interview, it was determined that the facility failed to identify, implement, monitor, and modify interventions consistent with the resident's needs for one of two residents reviewed for nutrition (Resident R52).</p> <p>Findings Include:</p> <p>Review of facility policy dated January 16, 2024, Recording The Weight of Each Resident revealed if a resident shows a 5% weight gain or loss, the Dietitian should be notified. Any resident with a significant weight loss should be included on the 24 hour report for that day.</p> <p>Review of Resident R52's comprehensive Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated March 13, 2024, revealed Resident R52 had moderate cognitive impairment and had diagnoses of weakness and Cerebral Vascular Accident.</p> <p>Observation of Resident R52 on October 15, 2024, at 11:05 a.m. revealed Resident R52 had bilateral hand tremors.</p> <p>Interview with Resident R52 on October 15, 2024, at 11:05 a.m. Resident R52 reported mealtimes can be difficult because the food falls off the utensil. Continued interview with Resident R52 revealed the resident will get frustrated at mealtimes and ends up not eating. Resident R52 reported history of weight loss.</p> <p>Review of Resident R52's clinical record revealed the resident was readmitted to the facility following a hospitalization on [DATE].</p> <p>Continued review of Resident R52's clinical record revealed the resident was weighed on March 8, 2024, at 168.5 pounds.</p> <p>Review of Resident R52's nutrition assessment dated [DATE], completed by Registered Dietitian, Employee E11, revealed Resident R52 had a fair appetite and was not able to feed self. Resident R52 was noted with meal intakes of 25-50%. Resident R52's nutritional needs were assessed based on intact skin at that time. Recommendations included to provide a 4-ounce supplement (contained 240 calories & 10 grams protein) one time per day to increase PO (by mouth) intake.</p> <p>Continued review of Resident R52's nutrition assessment dated [DATE], revealed the resident's nutrition diagnosis was inadequate PO intake related to diagnoses and advanced age, as evidence by meal consumptions of 25-50%.</p> <p>Review of Resident R52's medication/treatment administration, physician orders, and clinical record revealed no documented evidence the 4-ounce supplement as implemented as recommended by the Registered Dietitian, Employee E11, on March 12, 2024.</p> <p>Review of Resident 52's physician order history revealed a physician order with a start date of March 27, 2024, for a calorie count over 3 days and to send the results to dietary when completed.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R52's clinical record revealed no documented evidence the calorie count was completed as ordered. Continued review of Resident R52's clinical record revealed no documented evidence the Registered Dietitian followed-up with the ordered calorie count.</p> <p>Further review of Resident R52's clinical record revealed Resident R52 was noted with discoloration to the left sacrum on March 26, 2024. Resident R52 was subsequently assessed by the Nurse Practitioner, Employee E13, on April 2, 2024, who identified the area on the left sacrum as a stage 2 pressure ulcer (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer).</p> <p>Review of Resident R52's clinical record revealed Resident R52 was assessed by the Nurse Practitioner, Employee E13, again on April 9, 2024. The Nurse Practitioner, Employee E13, revealed the stage 2 pressure ulcer had worsened and was now categorized as an unstageable pressure ulcer (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar).</p> <p>Review of Resident R52's clinical record revealed no documented evidence the Registered Dietitian followed-up to reassess the resident's nutrition needs to align with Resident R52's increased calorie and protein needs to promote wound healing.</p> <p>Resident R52 was weighed again on April 4, 2024, at 158.3 pounds which reflected a 10 pound and 6.44% significant weight loss from March 8, 2024.</p> <p>Review of Resident R52's clinical record revealed the Registered Dietitian did not re-assess Resident R52's nutrition status and nutritional needs until April 26, 2024.</p> <p>Interview on October 18, 2024, at 12:36 p.m. with Registered Dietitian, Employee E12, confirmed Resident R52 had a significant weight loss from March 8, 2024, to April 4, 2024, and was not assessed until April 26, 2024.</p> <p>Further interview with the Registered Dietitian, Employee E12, confirmed the supplement was not implemented as recommended from the nutrition assessment on March 12, 2024. The Registered Dietitian, Employee E12, also confirmed there was no follow-up to the calorie count that was ordered by the physician on March 27, 2024.</p> <p>Registered Dietitian, Employee E12, was unable to provide evidence of the results from the calorie count.</p> <p>Continued interview on October 18, 2024, at 12:36 p.m. with Registered Dietitian, Employee E12, confirmed there was no nutrition follow-up to re-assess Resident R52's energy needs when the skin breakdown was identified on April 2, 2024.</p> <p>28 Pa. Code 211.10 (c) Resident care policies</p> <p>28 Pa. Code 211.12 (d)(3) Nursing services</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38735</p> <p>Based on a review of facility policy, review of clinical records, review of facility documentation, and staff interviews, it was determined the facility failed to implement a complete drug regimen review process for two of five residents reviewed for monthly medication review. (Resident R6 and R34).</p> <p>Findings Include:</p> <p>Review of the policy Medication Regimen Review dated June 28, 2019, revealed that the consultant pharmacist performs a comprehensive medication regimen review at least monthly. Findings and recommendations are reported to the Director of Nursing and Attending Physician. Recommendations are acted upon and documented by the facility staff and/or prescriber. Physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing.</p> <p>Review of Resident R6's medical record revealed that resident was admitted on [DATE], with diagnoses including dementia (general term for a decline in cognitive function).</p> <p>A review of the consultant pharmacist report for Resident R6 on July 21, 2024, included a recommendation to increase Memantine (medication to treat Alzheimer's type dementia) gradually to 10 milligrams (mg) twice a day for an optimal response.</p> <p>A review of Resident R6's physician orders for October 2024, revealed that the resident was still receiving 10 mg of Memantine once a day at bedtime as ordered on April 10, 2024.</p> <p>A review of Resident R6's physician progress notes revealed no review of the July 21, 2024, pharmacy recommendation to gradually increase the dose of memantine to 10 mg twice a day, to include what action, if any, would be taken and the rationale for not taking any action.</p> <p>Interview with the Director of Nursing on October 20, 2024, revealed that there was no documentation available to review related to the recommendations made by the consultant pharmacist or whether they were acknowledged by the physician and implemented or not and why.</p> <p>Review of Resident R34's physician order history and medication administration record revealed the resident was ordered Potassium chloride (mineral supplement used to treat or prevent low amounts of potassium in the blood) from July 6, 2024, through August 2, 2024, when the resident was discharged home.</p> <p>Review of facility documentation dated July 16, 2024, revealed that based on a monthly medication review for Resident R34, the consulting pharmacist recommended to administer Potassium chloride with 4 (ounces) of fluid or food to reduce the risk for esophageal erosion. The consulting pharmacist further specified to add directions to the medication administration record to avoid an error.</p> <p>Review of Resident R34's clinical record revealed no documented evidence the consultant pharmacist's recommendation from July 16, 2024, was addressed or implemented.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa. Code 211.9 (k) Pharmacy services.</p> <p>28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277</p> <p>Based on observations, review of facility policy, review of clinical records, and staff interview it was determined that the facility failed to implement enhanced barrier precautions for eight of eight residents reviewed (Resident R16, R48, R82, R88, R416, R4, R1)</p> <p>Findings Include:</p> <p>Review of facility policy dated November 2023 Enhanced Barrier Precautions revealed it is the policy of the facility to use enhanced barrier precautions with residents who are at risk for acquisition and colonization of multidrug resistant organisms (MDRO's). The use of Enhanced Barrier Precautions is indicated during high contact resident care activities for residents with chronic wounds and/or indwelling devices regardless of MDRO colonization.</p> <p>A review of Resident R16's clinical record revealed the resident was admitted to the facility on [DATE], and had a diagnosis of neuromuscular dysfunction of the bladder (neurogenic bladder, the relationship between the nervous system and bladder function is disrupted by injury or disease). Further review of Resident R16's clinical record revealed a physician order for a foley catheter (sterile tube that is inserted into the bladder to drain urine).</p> <p>Observation of Resident R16 in room [ROOM NUMBER]D on October 15, 2024, revealed resident resting in bed with eyes closed and a urine collection bag was hanging on the side of the bed. Further observation revealed no signage on the resident's door to indicate that the resident was on enhanced barrier precautions.</p> <p>Review of Resident R48's clinical record revealed a physician order dated March 27, 2024, for a coude catheter (type of urinary catheter to drain urine). Further review of Resident R48's clinical record including physician orders, progress notes, and comprehensive care plan revealed no documented evidence the resident was on enhanced barrier precautions.</p> <p>Review of Resident R82's clinical record revealed a physician order dated April 15, 2024, for a suprapubic catheter (a type of urinary catheter that is inserted into the bladder through an incision in the belly to drain urine). Further review of Resident R82's clinical record including physician orders, progress notes, and comprehensive care plan revealed no documented evidence the resident was on enhanced barrier precautions.</p> <p>Review of Resident R88's clinical record revealed a physician order dated May 10, 2024, for a suprapubic catheter. Further review of Resident R88's clinical record including physician orders, progress notes, and comprehensive care plan revealed no documented evidence the resident was on enhanced barrier precautions.</p> <p>Review of Resident R416's clinical record revealed a physician order dated October 2, 2024, for a foley catheter. Further review of Resident R416's clinical record including physician orders, progress notes, and comprehensive care plan revealed no documented evidence the resident was on enhanced barrier precautions.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observations of Resident R416 in room [ROOM NUMBER]D on October 15, 2024, at 10:26 a.m. revealed no signage on the resident's door and/or in the resident's room to indicate that the resident was on enhanced barrier precautions.</p> <p>Interview on October 16, 2024, at 11:45 a.m. with Registered Nurse, Employee E8, confirmed Resident R82, R88, and R48 had catheters. Further interview with Registered Nurse, Employee E8, revealed no residents were on enhanced barrier precautions.</p> <p>Follow-up observations on October 16, 2024, at 11:45 a.m. revealed no signage on the resident doors and/or in the resident rooms to indicate that Residents R82, R88, and R48 were on enhanced barrier precautions.</p> <p>Interview on October 17, 2024, at 11:11 a.m. with Infection Preventionist, Employee E9, confirmed enhanced barrier precautions were not in place.</p> <p>Review of Resident R4's clinical record revealed Resident R4 was admitted to the facility on [DATE] with the diagnoses of unspecified dementia; depression; essential hypertension, atherosclerotic heart disease of native coronary artery without angina pectoris; osteoarthritis of the knees; repeated falls; obstructive and reflux uropathy; and difficulty in walking.</p> <p>Further review Resident R4's October 2024 physician orders revealed an order for Coude Catheter 20 French/ 30 cwater. Catheter care every shift. Cleanse area with soap and water every shift.</p> <p>Observation of Resident R4's room did not reveal enhanced barrier precaution signage and there was no evidence of PPE (personal protective equipment) available outside room [ROOM NUMBER].</p> <p>Interview on October 16, 2024 at 11:30 a.m. with Employee E5 confirmed that staff does not wear a gown while performing urinary catheter care.</p> <p>Review of Resident R1's clinical record revealed Resident R1 was admitted to the facility on [DATE] with the diagnoses of heart disease of native coronary artery without angina pectoris.</p> <p>Observation of treatment to Resident's R1 sacral and heel wounds on October 17, 2024 at 10:40 a.m. with Wound nurse, Employee E15, and Licensed nurse, Employee E5, revealed hand sanitizer and and gloving were maintained. There was no transmission based signage or PPE (personal protective equipment) supply noted outside of room [ROOM NUMBER].</p> <p>Interview on October 17, 2024 at 11:00 a.m. with Employee E15 confirmed there was no transmission based precaution signage or PPE available during wound care for Resident R1.</p> <p>The facility did not implement enhanced barrier precautions related to catheter care and wound care.</p> <p>28 Pa. Code 211.10(d) Resident care policies</p> <p>28 Pa. Code 211.112(d)(1) Nursing services</p>		