STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395757	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgehill Nursing and Rehab Cen	146 Edgehill Road Glenside, PA 19038

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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 36609 Based on clinical record review and staff interview, it was determined that the facility failed to timely develop and implement a person-centered care plan to meet one resident's current needs for the use of a colostomy for one of three resident records reviewed (Resident R1). Findings including. Review of Resident R1's quarterly MDS (minimum data set, an assessment of resident's needs) dated June 21, 2024, revealed the resident was diagnosed with coronary heart disease, dementia, depression, anxiety and Parkinson's Disease (a progressive brain disorder), was incontinent of urine and used a colostomy for bowel elimination. The same MDS indicated the resident was cognitively impaired and dependent (helper does all of the effort) for toileting bathing, dressing and personal hygiene. Review of physician note dated March 7, 2024, revealed Resident R1 was readmitted from hospital following treatment for perforated viscus (a bowel or intestinal perforation). The resident underwent exploratory laparotomy, (to examine the abdominal organs) and low anterior resection with colostomy (an opening formed by drawing the healthy end of the colon through an incision in the anterior abdominal wall). Further review of Resident R1's clinical record revealed the facility failed to develop a comprehensive plan of care related to colostomy care that included goals and interventions. During an interview with the Director of Nursing on July 26, 2024, at 1:00 p.m. it was confirmed the facility failed to develop a comprehensive care plan for the resident's colonoscopy. 28 Pa. Code 211.10(c0 Resident care policies 28 Pa Code 211.12 (d)(3)(5) Nursing Services

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. 36609 Based on observations, interviews with resident and staff, review of clinical records and facility policy, it was determined that the facility failed to provide care to maintain grooming and personal hygiene for one of three residents reviewed (Resident R2). Findings include: Review of the facility's policy titled Incontinence Care states that the facility's policy is to observe the resident periodically throughout the day to provide the necessary incontinence care. The policy further states that the resident will be observed/check every 2-3 hours and/or individualized needs identified in the plan of care. Review of Resident R2's quarterly Minimun Data Set (MDS- resident's care assessemnt) dated May 7, 2024, revealed the resident was alert and oriented, diagnosed with multiple sclerosis (the immune system attacks and damages your brain and spinal cord), impaired on one side of the upper and both sides of the lower extremities. The same MDS identified the resident incontinent of urine and bowel and was dependent on staff for toileting, and bathing. An interview was conducted with Resident R2 on July 24 ,2024 at 11:00 a.m. regarding her inability to do her activities of daily living (ADL) anymore due to multiple sclerosis. The resident indicated that she likes showers but stated, The aides think it takes too long to get me ready for a shower. They use the Hoyer lift (a mechanical lift) to get me out of bed and they think it's faster to give me a bed bath instead. So, I don't get my showers twice a week and I don't know how long I go without getting my hair washed. The surveyor observed Resident R2 pointed out that her pants were soaked with urine. The resident stated she hadn't been changed since last shift which was approximately five hours ago. Review of Resident R2's plan of care revealed the resident's preference indicated that it was important that the resident have the opportunity to engage in daily routines that are meaningful relative to their preferences and important for the resident to choose between a tub bath, shower, bed bath or sponge bath and stated I prefer a shower dated April 22, 2024. The interventions developed regarding incontinence care were to establish voiding patterns and to check every two hours if incontinent and assist with changing briefs dated, April 9, 2024. On July 24, 2024, at 12:00 p.m. the Nursing Home Administrator confirmed Resident R2 did not have incontinence care since 6:00 a.m. 28 Pa. Code 201.29(j) Resident rights 28 PA Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(5) Nursing services

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 36609 Based on review of clinical records and interviews with staff, it was determined that the facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice when a changed of condition occurred for one of three resident records reviewed (Resident R1) Findings include: Review of Resident R1's quarterly MDS (minimum data set, an assessment of resident's needs) dated February 1, 2024 revealed the resident was diagnosed with dementia (brain disease) and Parkinson's Disease (a progressive brain disorder) and indicated the resident needed partial to moderate assistance (helper does less than half of the effort) for toileting, bathing, dressing and all personal hygiene and was incontinent of bowel and bladder. The same MDS revealed the resident's Brief Interview for Mental Status (BIMS) was an 11, indicating moderate impairment. Review of Resident R1's nursing progress note, written on the 11-7 shift, dated February 26, 2024, indicated at 11:30 p.m. (the night of February 25, 2024) the resident was Awake and complained of pain 10.5/10, pain on her lower abdomen. Nurse noted the resident was confused, vital signs were obtained and Tylenol was given with positive results. Continue review of the nursing progress notes revealed the next note was written almost two days later, dated February 27, 2024, at 6:56 p.m., This noted the resident was sent to the emergency room when the physician was notified of Resident R1's complaint of chest pain and shortness of breath. Further review of Resident R1's clinical record revealed no further nursing assessment documenting the status of the resident during this two day review period, failing to surmise the occurrence that took place leading to hospitalization . Interview with the Director of Nursing on July 25, 2024, at 1:00 p.m. indicated the nursing notes lacked the timeline and assessments of what took place during this time period and confirmed nursing failed to assess and document complete and accurate nursing progress notes. 28 Pa. Code: 211.12(d)(1)(5) Nursing services