

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395764	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Liberty Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 7310 Stenton Avenue Philadelphia, PA 19150	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923</p> <p>Based on review of facility policies, review of clinical records, facility documentation, staff and resident interviews, it was determined that the facility failed to ensure that residents were free from abuse for one of 18 residents reviewed (Resident R137).</p> <p>Findings include:</p> <p>A review of the clinical record indicated Resident's R137 was admitted to the facility on [DATE] with the diagnoses of severe intellectual disability (previously known as mental retardation characterized by limitation in intellectual functioning and adoptive behavior), restlessness and agitation, psychotic disorder with delusion, autism</p> <p>(autism spectrum disorder known as developmental disorder and effects communication, behaviors and social interaction), mood disorder.</p> <p>Review of Resident R137's Minimum Data Set (MDS - a periodic assessment of care needs) dated May 22, 2024, revealed a Brief Interview for Mental Status (BIMS) of 10 which indicated that the resident was moderate impairment.</p> <p>A facility investigation dated June 5, 2024, revealed the early morning of June 5, 2024, dietary staff, Employee E17 was walking towards the scene, stating that, the nursing assistant, Employee E18 was swinging the mopping stick in front of the Resident R 137. Employee E18 was removed from the scene immediately. Resident R137 was assessed by the charge nurse with no injury noted. All appropriate parties were notified. Upon the outcome of the investigation Employee E18 was terminated on June 5, 2024.</p> <p>A written statement from the nursing assistant, Employee E18 dated June 6, 2024 indicated on the night of June 6, 2024 [Resident R137] was behaving a little weird and he shoved me hard and roughly making my head hit against the wall as I was sitting down by the window. [Resident R137] ran out of the dayroom and I got up and proceeded behind him and he turned like he was coming after me. I grabbed the broom and tried to keep distance between us, and he came again, and I was swinging it to keep him back and he ran up and pushed me over the wheelchair.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an interview conducted by the director of nursing (DON), Employee E2 with Nurse aide, Employee E18 dated June 6, 2024 revealed that Employee E18 noticed that Resident R137 was acting a little strange and unbalance. Walking back and forth sat down, holding his head. I asked are you alright and he said, yes mam Resident R137 came to the day room, left and looked through the hallway window into the day room. I was doing the kiosk sitting at the table in the day room by the window.[Resident R137] came up and hit me on my shoulder and I told [Resident R137] not to do that. [Resident R137] went back to this room. Came back, looked through the window and ran showed me and my head hit the wall. Then I got up, he ran out and I got and came behind him, [Resident R137] stopped by the room B25 and I said don't be pushing me like that, that's not nice. [Resident R137] was smiling like it's a game. A broom was in the day room. I grabbed the broom; [Resident R137] looked like was coming towards me and pushed me over the wheelchair in the hallway by the room B17. Director of nursing, Employee E2 questioned if Nurse aide, Employee E18 hit the resident with a broom stick. Nurse aide, Employee E18 said no. DON, Employee 2 So, the broom stick did not touch the resident? Nurse aide, Employee E18 no it did not. DON, ake Why did you swing the broom at the resident? Nurse aide, Employee E18 because he turned around as if he's going at me again, to keep him back from getting to me. DON, Did you call for help before it got to the level of swinging the broom at the resident? Nurse aide, Employee E18 no because I didn't understand what just happened. DON, asked Instead what grabbing the stick, why didn't you walk away from the resident? Nurse aide, Employee E18 I should have but he already stopped by room B25, and I told him not to do that. The lady from the kitchen saw when he pushed me over the chair.</p> <p>A statement written by the Cook, Employee 17, revealed on June 5, 2024, at around 4:30 a.m. walking towards the 1st floor day room, I heard a CNA (don't know her name) saying he hit me. I figured it was Resident R137 because he had just left the day room as she was saying it. I can't recall if anything was in her hand at the time or if she picked up the mop handle from the hallway. I just saw it swing, I didn't see if she hit him because I was trying to get the attention of the nurse and CNA that be at the front desk.</p> <p>A statement written by the license nurse, Employee E19 dated 6/5/2024 revealed at about 4:20 a.m. I was at the nurses station when I heard a loud commotion at B wing when I rushed over there I saw a [NA, Employee E18] holding a mop stick, the Resident R137 was in front of the room B17, when I asked the case nurse what happened she stated that the resident pushed her against the wall. Then this writer asked her did you hit the Resident R137? NA, Employee E18 said no but I was swinging the mop to keep him away from me. This writer did not see CNA hit the resident.</p> <p>On August 1, 2024, at 10:07 a.m. an interview was held with the Cook, Employee E17 who revealed that she been employed at the facility for 6 years and starts her shift from 5 a.m. -2 p.m. On June 5, 2024, at approximately 4:20 a.m. she was coming from the lobby towards the kitchen and when she got to the day room she hurt a noise saying he hit me. Then she observed Resident R137 came out of the day room and NA., Employee E18 followed him. I turned around and called the charge nurse, Employee E19 Supervisor you need to come in and handle a situation. She came right away. I did not see a [NA, Employee E18] hit the resident. Not sure if CNA already had a broom stick or she grabbed it, but I did see a broom stick. I did not see CNA swing the stick.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On August 1, 2024, at 10:22 a.m. an telephone interview was held with license nurse, Employee E19 who reported that she was a charge nurse on June 6, 2024, it was approximately early morning around 4 a.m. I was at the nursing station doing my documentation and heard noise coming from the B wing hallway. I went and saw CNA holding and stick and resident was in the hallway. I asked what's going on [NA, Employee E18] responded he pushed me. I asked how did he pushed you? Did you hit him? [NA, Employee E18] said no. Resident R137 was standing in the hallway. I saw a stick in [NA, Employee E18] hand and she was not swinging it. I took the Resident R137 back to his room and conducted a nursing skin assessment. There were no injuries noted.</p> <p>An interview with Director of Nursing, Employee E2 on July 31, 2024, at approximately 11:40 a.m. revealed that Nurse aide, Employee E18 was terminated for not appropriately handling the situation with Resident R137. Facility has conducted an in-service abuse training on June 7, 2024-June 17, 2024, and in-service all their staff. In-service abuse training was validated with staff signing sheets.</p> <p>An interview with the Director of Nursing on August 1, 2024, at approximately 4:00 p.m. confirmed that Nurse Aide, Employee E18 did not acted appropriately with swinging a mop stick which placed a Resident R137 in a harmful situation.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(b)(e)(1) Management.</p> <p>28 Pa. Code 201.29(a)(j) Resident Rights.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347</p> <p>Based on review of clinical records, resident and staff interviews and review of facility policy, it was determined that the facility failed to conduct a complete and thorough investigation to rule out abuse related to one of one allegation of potential sexual abuse. (Resident R11)</p> <p>Findings include:</p> <p>Review of facility policy titled Abuse Prevention Program dated January 1, 2022, revealed the primary purpose of the policy is for the residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The following implementations are indicated in the prevention program; Separate the residents, identify what happened, notify each resident's representative of the incident ;review the events with the Nursing Supervisor and Director of Nursing, consult with the Attending Physician to identify treatable conditions such as acute psychosis that may have caused or contributed to the problem; make any necessary changes in the care plan approaches to any or all of the involved individuals; document in the resident's clinical record all interventions and their effectiveness; consult psychiatric services as needed for assistance in assessing the resident, identifying causes, and developing a care plan for intervention and management as necessary or as may be recommended by the Attending Physician or Interdisciplinary Care Planning Team; complete a Report of Incident/Accident form and document the incident, findings, and any corrective measures taken in the resident's medical/clinical record; and Report incidents, findings, and corrective measures to appropriate agencies as outlined in our facility's abuse reporting policy.</p> <p>Review of Resident R11's quarterly MDS (minimum data set- a mandatory periodic resident assessment tool) dated July, 2, 2024, revealed that the resident was admitted to the facility on [DATE], with diagnoses of Schizophrenia (a serious mental debilitating health condition that effects a person's thoughts, feelings, and behavior, characterized by hallucinations, delusions, disorganized thinking, and behavior., anxiety disorder, (a type of mental health condition that involves persistent and excessive worry) and psychotic disorder(a severe mental disorder that causes abnormal thinking and perception),and Bipolar disorder (a mental health condition that causes unusual intense shifts in mood, energy and behavior). Resident R11 was determined to be cognitively impaired with a BIMS (Brief interview for mental status- a mandatory tool used to screen cognitive conditions of residents) score of 14.</p> <p>Review of Resident R11's care plan, initiated January 11, 2024, revealed that Resident R11 has been identified as having a behavior problem related to pretending to be asleep and putting self on the floor. Resident R11 is also noted to refuse medications. Interventions included to monitor for behavior episodes, attempt to determine underlying cause, document behavior and potential causes.</p> <p>Review of resident's clinical records revealed a psychological note dated May 16, 2024, written by Employee E24, stated that He addressed complaints about him touching another resident and coming to her door when she did not welcome him. He denied touching resident, or going to her door, even talking with her despite a few different reports by staff and his peers witnessing him doing so.</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 Resident R42 's quarterly MDS dated [DATE] revealed that the resident was admitted to the facility on [DATE], with a diagnosis of Schizophrenia (a serious mental debilitating health condition that effects a person's thoughts, feelings, and behavior, characterized by hallucinations, delusions, disorganized thinking, and behavior., anxiety disorder, (a type of mental health condition that involves persistent and excessive worry)and psychotic disorder (a severe mental disorder that causes abnormal thinking and perception), dementia (a term used to describe a group of diseases and illness that effect thinking, memory, reasoning, personality an mood and behavior) and depression (a mental disorder that involves a depressed mood or loss of pleasure or interest in activities for long periods of time with symptoms affecting memory, thinking and social abilities.) Resident R42 was determined to be cognitively impaired with a BIMS (Brief interview for mental status- a mandatory tool used to screen cognitive conditions of residents) score of 8.</p> <p>Review of Resident R42's psychotherapy progress note dated May 16, 2024, written by Employee E 24, revealed the Reason for visit was Inappropriate peer/To help resident cope and handle the uncomfortable feelings.Resident shared about being uncomfortable with a peer. She agreed to set boundaries.</p> <p>Further review of Resident R 42's psychotherapy progress notes written by Employee E 24 dated June 5, 2024 revealed SW (Social Worker) met with/ the resident to discuss a concern she had about a male resident coming into her room. When what concern she had, she stated I have none, I'm over it, when asked what the concern was, she stated I was just mad at him because he was bringing up old stuff and I didn't want to hear it.</p> <p>Interview with licensed nurse unit manager, Employee E 8 on July 31, 2024, at 11:25 a.m. revealed that this was not investigated as an incident, but she did take a statement from the resident, R42. The incident with Resident R11 was described as Resident R42 was taking a nap and Resident R11 entered her room and bothered her. Resident R42 left her room and went to the nurse's station and reported that Resident R11 entered her room and would not leave. Employee E8 spoke to Resident R 11, and he became angry. Employee then requested that Social Worker, Employee E42 speak with resident R11.</p> <p>Interview with Resident R42 on July 31, 2024, at 11:45 am revealed Resident R11 lives on the floor, he came into her room and pulled at her arms, when asked what he wanted Resident R42 reported that he wanted her to hug and love him. Resident R42 repeatedly asked him to stop. Resident R42 reported the incident to Licensed nurse, Employee 8.</p> <p>Second interview with Resident R42 on August 1, 2024 revealed that no residents have touched her, no residents have kissed her, no residents have exposed themselves to her . Resident R 42 stated I feel safe.</p> <p>Interview with Social Worker, Employee E24 on August 1, 2024, at 12:25 p.m. revealed that he was requested to speak to Resident R 11 by the staff due to his behavior. Employee E 4 revealed that he usually is notified by staff of residents that need to be assessed. Employee E24 counseled Resident R11 on boundaries and distance from Resident R42.</p> <p>Employee E24 also assessed Resident R42; she has a history of abuse giving some concern of her relations with other male residents. The resident did not indicate that she felt unsafe.</p> <p>28 Pa. Code 201.14 (a) Responsibility of Licensee</p> <p>(continued on next page)</p>		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 211.12 (d) Nursing Services

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347</p> <p>Based on review of facility policy, clinical record review and interviews with staff, it was determined that the facility failed to ensure a Level II PASARR was conducted for residents with mental disorders as required for four of four residents reviewed. (Residents R1, R3, R20 and R36).</p> <p>Findings include:</p> <p>Review of facility policy titled Patient Access to Service and Record (PASR) Policy, not dated, revealed that the purpose of The PASARR screening is to ensure that individuals with mental illness and or intellectual disabilities are appropriately evaluated and placed in skilled nursing facilities with access to necessary services in compliance with federal and state regulations.</p> <p>Further review of the facility policy revealed the process of the PASARR evaluation begins with a preadmission screening, all prospective residents will undergo a PASARR screening prior to admission, if an individual level 1 screening indicates a potential mental illness, a level II evaluation will be completed. Admission to the facility will be contingent upon completion of the PASARR process to ensure the facility can meet the identified needs of the individual.</p> <p>Continued review of the policy revealed that the facility will conduct regular audits to ensure compliance with PASARR requirements.</p> <p>Review of Resident R1's quarterly MDS (minimum data set- a mandatory periodic resident assessment tool) dated May 3, 2024, revealed that the resident was admitted to the facility on [DATE], and the resident had a Level II PASARR (Pennsylvania Preadmission Screening Resident Review- a process for screening and evaluating all residents for mental disorders and intellectual disabilities) condition related to a serious mental illness. Continued review of the MDS assessment revealed that the resident had a diagnosis of Schizophrenia (a serious mental debilitating health condition that effects a person's thoughts, feelings, and behavior, characterized by hallucinations, delusions, disorganized thinking and behavior).</p> <p>Review of Resident R 1's Level 1 PASARR form, dated February 21, 2018, revealed the resident met the criteria to have a Level II evaluation.</p> <p>Continued review of the clinical record revealed that there was no indication in the record that a Level II PASARR evaluation had been completed.</p> <p>Review of Resident R3 quarterly MDS (minimum data set- a mandatory periodic resident assessment tool) dated May 17, 2024, revealed that the resident was admitted to the facility on [DATE], and that the resident had a Level II PASARR condition related to a serious mental illness. Continued review of the MDS assessment revealed that the resident had a diagnosis of Schizophrenia (a serious mental debilitating health condition that effects a person's thoughts, feelings, and behavior, characterized by hallucinations, delusions, disorganized thinking, and behavior., anxiety disorder, (a type of mental health condition that involves persistent and excessive worry) and psychotic disorder(a severe mental disorder that causes abnormal thinking and perception) .</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R3's Level 1 PASARR form, dated August 14, 2018, revealed the resident met the criteria to have a Level II evaluation.</p> <p>Continued review of the clinical recorded revealed that there was no indication in the record that a level II PASARR evaluation had been completed.</p> <p>Review of resident R20's quarterly MDS (minimum data set- a mandatory periodic resident assessment tool dated June 5, 2024, revealed that the resident was admitted to the facility on [DATE], and readmitted [DATE], that the resident had a Level II PASARR condition related to a serious mental illness. Continued review of the MDS assessment revealed that the resident had a diagnosis of Schizophrenia (a serious mental debilitating health condition that effects a person's thoughts, feelings, and behavior, characterized by hallucinations, delusions, disorganized thinking, and behavior, and a diagnosis of depression (a mental disorder that involves depressed mood of loss of pleasure of interest in activities for long periods of time).</p> <p>Review of Resident R 20's Level 1 PASARR form, dated May 23, 2019, revealed the resident met the criteria to have a Level II evaluation.</p> <p>Continued review of the clinical recorded revealed that there was no indication in the record that a level II PASARR evaluation had been completed.</p> <p>Interview with Employee Interview with employee E23, social worker, on July 31, 2024 at 2:20 p.m. confirmed that a level II PASARR evaluation had not been completed for Residents R1, R3, and R20 as required.</p> <p>Clinical record review revealed Resident R36 was admitted to the facility July 14, 2022 with a diagnosis that included but not limited to Post Traumatic Stress Disorder (mental illness triggered by a terrifying event, either experiencing it or witnessing it), Bipolar Disorder (mental illness that causes mood episodes that ranges from extremely high to extremely low), Dementia (the loss of cognitive functioning that interferes with daily life), and Anxiety (mental health condition that involves persistent and excessive worry).</p> <p>Review of Resident R36 PASARR 1 form, dated July 12, 2022, revealed that Resident R36 met the criteria to have a Level II PASARR evaluation completed.</p> <p>Continued review of the clinical record revealed that there was no indication in the record that a Level II PASARR evaluation had been completed.</p> <p>Interview with Employee E23, social worker, on August 01, 2024 at 11:51 a.m, confirmed Level II PASARR evaluation had not been completed for Residents R36 as required.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923</p> <p>Based on observation and staff interview, it was determined that the facility failed to ensure that the environment remained free of accident hazards for one out of the 37 residents reviewed and had residents would have appropriate supervision. (Resident R30)</p> <p>Findings include:</p> <p>A review of the clinical record indicated Resident R30 was admitted to the facility on [DATE] with the following diagnosis schizophrenia (chronic and severe mental disorder which includes hallucination, delusion, disorganized thinking, agitation or erratic behaviors) and major depressive disorder (feeling sadness, loss of interest, significant change in weight or appetite, feeling of worthlessness, difficult concentrating or making decisions).</p> <p>Review of Resident R30's Minimum Data Set (MDS - a periodic assessment of care needs) dated May 3, 2024, revealed a Brief Interview for Mental Status (BIMS) of 15 which indicated that the resident was cognitively intact.</p> <p>A comprehensive care plan was developed on June 9, 2022 which revealed that Resident R30 had behaviors such as manipulative behavior, refusing be seen by the wound team, accusing staff of giving wrong medication, refusing ADLs, video recording staff, likes to block the exit doors, non-compliant with isolation precautions, hoarding behavior and refusing staff assistance with cleaning.</p> <p>An interview was held on July 29, 2029, at 11:41 a.m. with Resident R30 revealed an observation of three large 5 gallon bottles with blue substance being on the floor. When questioned what's the blue substance Resident R30 reported that cleaning supplies for his commode. When started to question what kind of cleaning supplies or how the resident received the cleaning supplies, Resident R30 started to become verbally aggressive frustrated.</p> <p>An interview with Director of Nursing, Employee E2 on July 29, 2024, at 12:20 p.m. confirmed that Resident R30 had unknown cleaning supplies in his room on the floor and agreed to place the cleaning bottles into his closet under the locked lock. The lock and the key were provided to the resident.</p> <p>On August 1, 2024, an observation was held with the Director of Nursing, Employee E2 which revealed Resident R30 no longer had the cleaning supplies in his room and reported that his family came in and took it away.</p> <p>On July 29, 2024, at 11:06 a.m. second floor D nursing unit dining area had 6 resident sitting in the dining room who were not alert and oriented with no staff.</p> <p>On July 30, 2024, at 10:10 a.m. first floor activity room had approximately 6-7 residents in the room with no supervision. Regional Nurse, Employee E15 confirmed the observations.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On August 1, 2024, at 9:47 a.m. Resident R5 was observed being outside on his own sleeping with no staff supervision. Nursing Aid, Employee E16 was in the hallway next to the activity room on B wing had to come to the window to identify the resident and reported that activity staff should be outside.</p> <p>On August 1, 2024, at 9:42 a.m. a Resident R78 barricaded himself in the second-floor shower using his wheelchair and staff were observed to try to open the door.</p> <p>On August 1, 2024, at 9:52 a.m. a Resident R78 was heard to be in the second-floor shower with no staff. Director of Nursing, Employee E2 walked in and confirmed that Resident R78 was taking a shower with no supervisor.</p> <p>CFR. 483.25(d)(2) Accidents.</p> <p>28 Pa. Code 211.12(d)(5) Nursing services.</p> <p>28 Pa Code 201.14(c) Responsibility of licensee</p> <p>28 Pa Code 201.18(b)(1) Management</p> <p>28 Pa Code 211.12(d)(1)Nursing services</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395764	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Liberty Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 7310 Stenton Avenue Philadelphia, PA 19150	
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>51165</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure that a resident's medication regime was free from potentially unnecessary medications for one of four residents reviewed (Resident 68).</p> <p>Findings include:</p> <p>Facility policy titled Policy for Psychotropic Use in Long-Term Care (LTC), indicated that The facility will adhere to all relevant federal, state, and local regulations regarding the use of psychotropic medications in LTC settings.</p> <p>Clinical record review revealed Resident R68 was admitted to the facility February 09, 2022, with a diagnosis that included but not limited to Cerebral Infarction (disruption of blood supply to the brain that causes brain tissue death), Schizophrenia (mental health condition that affects how people think, feel, and behave), and Altered Mental Status.</p> <p>Review of Resident R68's medication orders revealed a physician order initiated June 28, 2024 to administer Ativan 0.5 mg (anti-anxiety medication) orally (by mouth) every four hours as needed for anxiety. The medication order indicated a stop date of indefinite, which lacked the required stop date within 14 days</p> <p>Review of Resident R68's pharmacy notes to attending physician/prescriber dated July 11, 2024, revealed a recommendation If you believe this resident's PRN order for Ativan is appropriate beyond 14 days- see CMS regulations below, then follow the instructions below: 1. if the PRN order is to continue, please document your rationale and indicate the duration of therapy in the resident's medical record or below. 2. Please write a new order, if it should continue, prior to the 14 days. Per CMS, this new order must include a duration of use, i.e 30 day, 60 day, 3 months, ect. The physician responded on July 11, 2024, resident is on hospice and prone to agitation. The physician failed to indicate a duration of PRN Ativan.</p> <p>Further review of clinical record revealed PRN Ativan 0.5 mg was ordered for anxiety. Resident R68 had no documented diagnosis for anxiety. The facility failed to ensure psychotropic medication was used to treat a specific condition as diagnosed and documented in the clinical record.</p> <p>During an interview on August 01, 2024, at 10:25 am, Director of Nursing confirmed that Resident R68 lacked the required stop date within 14 days. During an interview on August 01, 2024, at 12:41 pm, Medical Director confirmed that Resident R68 lacked a proper diagnosis that was documented in the clinical record.</p> <p>28 Pa. Code 211.2(d)(3) Medical director</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<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>46508</p> <p>Based on review of clinical records, review of facility policy, observation, and staff and resident interviews, it was determined that the facility failed to ensure that all drugs and biologicals are stored and labeled in accordance with professional standards. For one of eighteen residents reviewed. (Resident R40).</p> <p>Findings include:</p> <p>Review of the facility policy and storage of medication revealed that under section policy statement, the facility stores all drugs and biologicals in a safe, secure and orderly manner under section Policy Interpretation and Implementation #1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. #3 The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. #4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. #8 compartments, including but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes containing drugs and biologicals are locked when not in use. #12 Only persons authorized to prepare and administer medications have access to lock medications.</p> <p>Observation conducted during tour of the first floor A unit on July 29, 2024 at 11:42 am revealed that Resident R40 was in bed awake.</p> <p>Further observation revealed a tube of Medihoney on resident's overhead table which was next to her.</p> <p>Interview with Resident R40 conducted at the time of the observation revealed that she has an ulcer on her bottom. Further, Resident R 40 revealed that a nurse left the Medihoney with her.</p> <p>Interview with DON Employee E2 conducted at the time of the observation confirmed that the Medihoney was with resident R40. Further Employee E2 revealed that a nurse's aide left the medihoney with the resident.</p> <p>Further interview with Employee E2 revealed that the Medihoney should not be with the resident and that it should have been stored in the locked treatment cart.</p> <p>28 Pa. Code 201.8(b)(l) Management</p> <p>28 Pa. Code 211.12(d) Nursing services</p>		

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or get specialized rehabilitative services as required for a resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923</p> <p>Based on review of facility policy, review of clinical records, observations and staff interviews, it was determined that the facility failed to assess the need for specialized occupational therapy services according to the professional standards of practice for one out of one resident reviewed for rehabilitation services (Resident R18).</p> <p>Findings include:</p> <p>Review of facility policy Standards and Guidelines: Restorative Nursing Services dated August, 2022, revealed that To promote the resident's optimum function, a restorative nursing program may be developed by proactively identifying, care planning, and monitoring of a resident's assessments and indicators, Restorative nursing program refers to interventions that promote the resident's ability to adopt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental and psychosocial functioning. Restorative programs may be initiated by nursing and/or therapy.</p> <p>A review of the clinical record indicated Resident R18 was admitted to the facility on [DATE] with the following diagnosis age-related osteoporosis (bones become weak and brittle due to aging), need for assistance with personal care, abnormalities of gait and mobility, muscle weakness, psychomotor deficit, lack of coordination, and dementia (range of progressive neurological disorders that affect memory, thinking, behavior, and the ability to perform everyday activities).</p> <p>Review of Resident R18's Minimum Data Set (MDS - a periodic assessment of care needs) dated June 7, 2024, revealed a Brief Interview for Mental Status (BIMS) not recorded which means the resident was unable to participate in the assessment due to severe cognitive impairment.</p> <p>A family interview was conducted on July 29, 2024, at 12:27 p.m. with Resident's R18 daughter who reported that her mother had not been walking and she needs assistance to walk.</p> <p>An interview with the Rehabilitation Director, Employee E13 who reported that Resident R18 was discharged from physical therapy on June 10, 2024, and started a restorative program on June 11, 2024. The restorative nursing program included the following interventions: Ambulation - 140 feet in increments using a RW (Rolling Walker) with Contact Guard to Minimum Assistance (25-50% assistance) of 1 person, with verbal and tactile cues for direction, for AD (assistive device) maneuvering, for maneuvering around the obstacles and for increased hip and knee flexion to clear the floor. Second intervention was for transfers - 90 degree or 180 degree turns to facilitate SPT (stand pivot transfers) and STS (sit to stand transfers) with RW (Rolling Walker) with Contact Guard to Minimum Assistance (25-50% of assistance) of 1 person. These two-intervention needed to be done on daily bases. Further interview revealed that facility had a restorative aid, Employee E14 which last worked on June 11, 2024, when she was trained how to appropriately implement the two interventions for Resident R18. Then Employee E14 had life threatening event which placed her in a coma. Facility had not had any other staff provide restorative program to any residents.</p> <p>(continued on next page)</p>

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On August 1, 2024, at approximately 10:30 a.m. an interview was conducted with Director of Nursing, Employee E2 who reported that Administrator oversees restorative program. The nursing staff do not provide restorative program to any of the residents.</p> <p>On August 1, 2024, at 12:47 p.m. an interview was conducted with the Administrator, Employee E1 who reported that Restorative Aid, Employee E14 has not worked since June 11, 2024, and the facility has not trained any staff to implement the restorative program for any of the residents. Administrator, Employee E1 confirmed the facility intends to hire a new restorative aide; however, it has not provided the restorative program to any of its residents.</p> <p>28 Pa Code: 201.18(e)(1) Management.</p> <p>28 Pa. Code: 211.10(c)(d) Resident care policies.</p>		

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>48347</p> <p>Based on review of facility documentation and staff interview it was determined that the facility failed to ensure a designated infection prevention (IP) works at the facility focusing only on infection control at least part time as required one or more individuals servicing as infection Preventionist responsible for the facility's infection prevention plan.</p> <p>Finding include:</p> <p>Review of facility documentation identified the Director of Nursing (DON) fulfilled the job of Infection Preventionist. The DON works full time and was unable to provide valid proof that additional part time hours focusing only on infection control were completed in addition to his/her full time DON duties.</p> <p>Review of the Infection preventionist (IP) job description revealed that the IP is responsible for the activities aimed at healthcare associated infections. The responsibilities include collecting, analyzing health data, and interpreting, implementing, and evaluating public health practices. The IP will conduct education and training on healthcare associated infections for staff and management.</p> <p>Interview on July 31, 2024, at 1:40 p.m. with DON Employee E 2 revealed that she has been the IP and DON, she is able to divide her time. she states while working at infection control, her director of nursing assistant can cover the floor.</p> <p>The Administrator and Director of Nursing were asked to provide official documentation that the DON was at the facility after her work hours conducting infection control business. There was no time stamped computer notes or punch report evidence provided that the DON worked additional hours .</p> <p>28 Pa. Code 210.18(e)(1) Management</p> <p>28 Pa Code 211.12 (d)(1) Nursing Services</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508</p> <p>Based on Review of clinical record, review of facility policy and interview with staff, it was determined that the facility failed to ensure that residents were provided with education regarding the benefits and potential side effects of influenza immunization for three of three residents (Residents R85, R8 and R17).</p> <p>Findings:</p> <p>Review facility policy on Influenza Vaccine revealed that under Section Policy Statement, all residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccination against influenza. The facility shall provide pertinent information about the significant risks and benefits of vaccines to staff and residents or residents legal representatives. For example, risk factors that have been identified for specific age groups or individuals with risk factors such as such as allergies and pregnancy. Under section Policy Interpretation and Implementation. #1 Between October 1st and March 31st each year, the influenza vaccine will be offered to residents and employees unless the vaccine is medically contraindicated, or the resident or employee has already been immunized. #2 employees hired or residents admitted between October 1st and March 31st, will be offered the vaccine within 5 working days of the employee's job assignment or the resident's admission to the facility. #4 Prior to the vaccination, the resident or resident's legal representative, will be provided information and education regarding the benefits and potential side effects of the influenza vaccine.</p> <p>Review of Resident R85's clinical record revealed that Resident R85 was admitted to the facility on [DATE].</p> <p>Further review of resident R85's clinical record revealed no documented evidence that Resident R85 or Resident R85's representative was provided education regarding the benefits and potential side effects of influenza immunization.</p> <p>Review of Resident R8 clinical record revealed that Resident R8 was admitted to the facility on [DATE].</p> <p>Further review of Resident R8's clinical record revealed no documented evidence that Resident R8 or Resident R8's representative was provided education regarding the benefits and potential side effects of influenza immunization.</p> <p>Review of Resident R17's clinical record revealed that resident R17 was admitted to the facility on [DATE].</p> <p>Further review of Resident R17's clinical record revealed no documented evidence that Resident R17 or Resident R17's representative was provided education regarding the benefits and potential side effects of influenza immunization.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the DON (Director of Nursing) Employee E2 conducted on July 31, 2024, at 1:14pm confirmed that the facility did not have documented evidence that residents or resident representatives were provided with education regarding the benefits and potential side effects of influenza immunization. Further Employee E2 also revealed that moving forward, the facility will initiate a form for influenza education and documentation.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 211.12(d)(1)(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 - Few</p>	<p>Keep all essential equipment working safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347</p> <p>Based on observations of the food and nutrition department, and interview with staff, it had been determined that the facility failed to maintain essential food service equipment in a safe operating condition relating to a gas stove control knobs and kitchen exhaust fan.</p> <p>Findings Include:</p> <p>Review of facility policy titled Supplies and Equipment, Environmental Services revised February 2009, revealed equipment must be always ready for use at all times.</p> <p>An initial tour of the main kitchen conducted on July 29, 2024, at 09:35 AM with employee E 25</p> <p>with Dietary director, revealed the facility had five refrigerators, four are functioning and one is out of order, and a gas oven/ grill with no knobs to be used for igniting the flame and controlling the amount gas to the range for temperature adjustment.</p> <p>Interview with Employee E17 on July 30, 2024, at 8:10 a.m. during breakfast preparation revealed that for an individual to use the stove without any knobs, in the kitchen there is a plastic knob on the shelf to be placed over the valve and turn. Employee E17 then demonstrated the knob, which was unsuccessful at turning the gas on. She tried again and the gas ignited. Employee E 17 revealed that she has been employee for six years and the oven has never worked in that period. There is another commercial convection oven that is used was the exhaust fan is functioning.</p> <p>Review of the facility menus for the week of the survey revealed the entree choices for lunch and dinner were sandwiches that included hot dogs, ham and cheese, roast beef sandwich, tuna salad, egg salad, turkey sandwich served with sides including potatoes salad , [NAME] slaw, potato chips, cheese curls, corn salad, beet salad and tossed salad.</p> <p>Interview with dietician employee E 26, revealed that kitchen is serving a cold menu due to the kitchen exhaust not functioning. Making the conditions in the kitchen intolerable for the kitchen staff. Employee E 26 provided evidence that the menus meet the dietary requirements and is a temporary menu.</p> <p>Review of the exhaust fan manufactures manual revealed that the centrifugal upblast fan is the industry standard for efficient air extraction. Originally for the commercial kitchen industry, these fans have backward inclined blades that utilize centrifugal properties to remove the grease and particulates from the air stream while preventing excessive build-up on the blades.</p> <p>Review of the National Fire Protection and Association which explicitly states the need for all components of the commercial kitchen exhaust system, including hoods, ducts, upblast exhaust fans, and fire-extinguishing systems, to be kept in working condition (4.1.3).</p> <p>Interview with NHA Employee E1 revealed that the exhaust fan has been ordered and has provided the original estimate dated July 5, 2024. Employee E 1 also provided deposit payment dated July 19, 2024. Installation was determined to be the week of August 4, 2024.</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 - Few</p>	<p>28 Pa. Code 207.2(a) Administrators responsibility</p> <p>28 Pa. Code 211.6(d) Dietary Services</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923</p> <p>Based on observations and staff interviews, it was determined that the facility failed to ensure a safe, functional, and sanitary environment for residents, staff, and the public on four out of four nursing units. (A, B, C, D nursing units)</p> <p>Findings include:</p> <p>On July 29, 2024, from 10:33 a.m. to 11:06 a.m. observations were conducted on the D unit revealed the following:</p> <p>Room D15 had no baseboard from the door to the bedside dresser, the room had a strong urine smell and sticky floors.</p> <p>Room D25 bed by the window had a missing shelf from the dresser, large, ripped cardboard box was on the floor with the box being overloaded with random resident's items in the box.</p> <p>Room D14 window bed had boxes and random bags on the floor which cluttered the pathway to get around the resident's rooms.</p> <p>Room D17 there was stool in the bathroom floor and all around the toilet, the bed next to the door had no baseboard from the door to the bed dresser. The room had sticky floors, strong stool smell in the room. Resident's closet did not have a right side doorknob.</p> <p>On July 29, 2024, at 11:07 a.m. the assistant of director of nursing, Employee E4 confirmed the above observations.</p> <p>On July 29, 2024, at 12:51 p.m. the second floor D unit dining floor was missing a baseboard on the left side by the sink and two tiles are missing from the floor and 6 tiles are broken off. Administrator Employee E1 confirmed the observations.</p> <p>On July 29, 2024, at 1:14 p.m. observation revealed that Resident R4 in room D20 had no call bell. Call bell was observed to be cut off and hanging wires from the light above the bed. Resident R18 in Room D22 had her call bell ripped and disconnected from the wall. Maintenance Director, Employee E7 confirmed the observations.</p> <p>Room D22 The cover of the internet outlet is detached from the wall.</p> <p>Room D21 was missing a full door to the closet and 1 drawer was broken. Resident R78 had a missing call bell wire. License nurse, Employee E9 confirmed the above observations.</p> <p>(continued on next page)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On July 29, 2024, at 2:45 p.m. an interview with the Maintenance Director, Employee E7 confirmed that call bells were broken on the following units: C wing-rooms C4, C5. B unit rooms B16, B17, B18, B24. Nursing unit A had the following rooms with the broken call bell: A2, A4, A9, A10, A11. Employee E7 reported that he was unaware of the broken call bells and emphasized the need for an in-service session for all nursing staff to ensure they alert maintenance when a call bell isn't functioning.</p> <p>Observation conducted during the tour of the first-floor unit A wing together with DON (Director of Nursing) Employee E2 revealed that Room# 00009-A, the call bell did not work, Room# 00022-B the call bell did not work, Room# 00010-B, the call bell prong was inserted not into the call bell socket. Further observation revealed that the call bell cord was cut from the base of the call bell plug/prong and did not have a cord and did not have a call button attached.</p> <p>Observation conducted during the tour of the first-floor unit B wing together with Employee E2 revealed that room [ROOM NUMBER]-2, the call bell cord was not clipped to the bed and call bell was not within reach of the resident, room# 00016-1 did not have a cord, room# 00017-1, call bell did not work, room# 00017-2, call bell did not work, room# 00018- 2, call bell was not working. Interview with Resident R8 (resident who lives in room# 00018-2, revealed that the call bell has not been working for a month now. Further, Resident R8 also revealed that he reported it a couple times but was never fixed, Room# 00020, call bell . was on the floor next to roommate's bed, further, the call bell was not within reach of the resident, room# 00025-1 the call bell was not clipped to the bed and was on the floor under bed-2 out of reach of resident, room# 00024-1, the call bell cord was cut from the base of the call bell plug/prong, there was no cord and there was no call button.</p>