STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395764	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Center for Rehabilitation and Nursing	7310 Stenton Avenue Philadelphia, PA 19150

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, review of facility policy, and review of facility documentation it was determined that the facility did not ensure that a complete and thorough investigation related to abuse allegation was completed for one of twenty residents reviewed. (Resident R83)Findings include: Review of facility policy titled Abuse Prevention Program, review date March 2017, revealed as the Policy Statement Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The policy continues, stating (administration will): 6. Identify and assess all possible incidents of abuse; 7. Investigate and report any allegations of abuse within timeframes as required by federal requirement; 8. Protect residents during abuse investigations; 9. Establish and implement a QAPI review and analysis of abuse incidents; and implement changes to prevent future occurrences of abuse. Review of Resident R83's clinical record revealed that the resident was initially admitted to the facility on [DATE], with diagnoses including by not limited to Major Depressive Disorder (severe, often recurring mood disorder marked by persistent feelings of low mood and loss of interest in pleasurable activities), hypertensive heart disease without heart failure (high blood pressure causing changes in the heart without heart's losing the ability to pump blood efficiently), and Type Two Diabetes Mellitus (impaired ability of the body to regulate blood sugar, caused by lack of sensitivity to or production of insulin). Review of Resident R83's Minimum Data Set (MDS - a federally required resident assessment completed at a specific interval) completed December 18, 2025, section C0500 BIMS (Brief Interview of Mental Status) revealed that Resident R83 had a BIMS score of 9, suggesting moderate cognitive impairment. Review of documentation submitted to the State Survey Agency on December 23, 2025 revealed an allegation of sexual assault made by Resident R83 (female) involving Resident R46 (male) with BIMS score 14 (suggestive of no cognitive impairment), was reported to have occurred on December 20, 2025; the report alleged that during this incident, Resident R46 entered Resident R83's room, pulled up her shirt and started to suck on her breast. Interview with Resident R83 on May 13, 2026 at 10:49 AM revealed that during said incident, Resident R83's roommate, Resident R85, was present, but that she doesn't understand what's going on. Review of clinical records revealed that Resident R83's former roommate, Resident R85 (room D223-2) has a BIMS score of 3, indicating severe cognitive impairment. Resident R85 was not interviewed by the facility. Review of facility's Investigation Report revealed no statements from any other residents besides Resident R83 and R46 were included in the report, relating to any issues with Resident R46. Review of separate documentation submitted to the State Survey Agency on April 29, 2026, related to an incident that occurred approximately a week prior to that (estimated in report as April 21, 2026), revealed that female Resident R83 alleged that on this date, male Resident R46 entered her room and inappropriately touched her legs and breasts. Review of facility's Investigation Report revealed only two staff interviews were included in the report after the April 2026 incident: one from the DON, Employee E2, and one from Resident R83's Licensed Nurse at the time of the incident, Employee E23. Additionally, no statements from any other residents aside from the Residents (continued on next page)

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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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	involved (Residents R83 and R46) were provided. Further review of facility's Investigation Reports for both the December 2025 and April 2026 revealed no copies of police reports were included in the documentation, with no mention of a police report having been made with respect to the December 2025 incident. Review of facility documentation revealed Resident R46 was admitted to the facility on [DATE] with the following diagnosis: Type Two Diabetes (a chronic condition where your body either resists the effects of insulin or doesn't produce enough to maintain normal glucose levels), Bi-Polar Disorder (a mental health condition characterized by extreme, cyclical shifts in mood, energy, and activity levels), Hypertension (a chronic condition in which the force of blood against your artery walls is consistently too high), Kidney Disease (your kidneys are damaged and cannot filter blood properly), Acquired absences of the left and right leg above the knee, and Insomnia (a common sleep disorder characterized by difficulty falling asleep, staying asleep, or waking up too early and struggling to go back to sleep). Review of facility documentation revealed Resident R83 was admitted to the facility on [DATE] with the following diagnosis: Major Depressive Disorder (a serious mood disorder characterized by pervasive low mood and loss of interest), Hypertensive Heart Disease (structural and functional heart damage caused by chronic, uncontrolled high blood pressure), Osteoarthritis (the most common form of arthritis), Hyperlipidemia (high levels of lipids (fats), such as cholesterol and triglycerides, in the blood), and Type Two Diabetes (a chronic condition where your body either resists the effects of insulin or doesn't produce enough to maintain normal glucose levels). Review of the facility investigation for Resident R83 revealed the resident first reported an incident of possible sexual abuse to the facility on December 20, 2025. Review of facility documentation revealed a Grievance/Concern form completed on December 20, 2025 and signed by licensed nurse Employee E5, That man Resident R46 came into my room lifted up my shirt and put his mouth on my breast. Resident R83 said the incident happened today. Review of facility documentation revealed a statement from licensed nurse Employee E5 that stated, On Saturday December 20, 2026 I was the charge nurse on 7 a.m.- 3p.m on the second floor D-Wing. I was called to room D23 by the nurse aide on that assignment in reference to resident R83. Resident stated, Resident R46 came into my room yesterday and lift up my shirt and put him mouth on my breast. Full head to toe assessment complete skin intact with no bruising, bleeding or any issues noted. I did not witness Resident R46 go into Resident R83's room. Review of facility investigation revealed a resident written interview held with the Director of Nursing and Resident R83 on April 28, 2026 states. Director of Nursing: Resident R83 is everything okay with you? Resident R83: No I can't take him. Director of Nursing: Who? Resident R83: Resident R46 I can't take him. Director of Nursing: What is he doing to you? Resident R83:He will be rubbing my legs and touching my breasts too. I am sick of him. Director of Nursing: When did this happen? The last time was last week. I didn't tell anyone but I told the nurse yesterday. I am sick of him. He asked me how am I doing and I told him to mind his business. I just want to change my room. I tell him to keep his hands off of me. He asked can he be my boyfriend and I said no I have my man that I do love. I want him off me. Director of Nursing: Can you make sure you scream for help and use your call bell when next he goes to your room? Resident R83: Yes, I will do that Further review of both facility investigations from December and April with Resident R83 revealed there were no interviews or statements taken from any residents. The above findings were confirmed on May 13, 2026 at 1:11 p.m. by the Director of Nursing Employee E2. The Director of Nursing admitted , we dropped the ball on these, I know this. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18 (b)(1)(3)(e)(1) Management28 Pa. Code 211.12 (d)(1)(2)(5) Nursing services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, review of facility policy and interview with staff, it was determined facility did not implement and maintain an effective infection prevention control program related to water management program and enhanced barrier precautions on one of four units observed. (Unit C)Findings include: Review of facility policy ?Enhanced Barrier Precautions (EBP) Policy and Procedure,' effective date April 1, 2024, indicates that EBP are indicated for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO (Multi Drug Resistant Organism) colonization status, infection or colonization with an MDRO when contact precautions do not otherwise apply. Further review of policy indicates that effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care. eview of facility policy ?Legionella Water Management Program,' revised July 2017, indicates that the purpose of water management program is to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. Further review of policy revealed that facility's water management program includes the following:A detailed description and diagram of the water system in the facility,The identification of areas in the water system that could encourage the growth and spread of legionella or other waterborne bacteria;The identification of situation that can lead to legionella growth'Specific measures used to control the introduction and/or spread of legionella (e.g., temperature, disinfectants);The control limits or parameters that are acceptable and that are monitored;A diagram where control measures are applied'A system to monitor control limits and the effectiveness of control measures;A plan for when control limits are not met and/or control measures are not effective;Documentation of the program. Observations on second floor unit, C-wing, on May 11, 2026, at 10:00 am, revealed Residents R12, R27, R7, R16 and R34 on EBP. Further observations of C-wing unit revealed no evidence of available PPE. Interview with licensed nurse assigned to residents on C-wing, Employee E10, on Monday, May 11, 2026, at 11:00 am, confirmed no available PPE was provided on that unit. Interview with facility's Maintenance Director, Employee E4, and Administrator, Employee E1, on Wednesday, May 13, 2026, at 11:00 am, conformed facility does not have control measures implemented as per policy for water management program. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 211.10(c)(d) Resident care policies 28 Pa Code 211.12(d)(5) Nursing services

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, and interviews with staff it was determined that the facility did not ensure a clean, comfortable, homelike environment for two of four nursing units reviewed. (C-Wing and D-Wing)Findings include: Review of facility policy titled, Quality of Life-Homelike Environment revised May 2017 states, Policy Statement- Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Further review of the policy states, 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Clean, sanitary, and orderly environment. Review of facility policy ?Quality of Life - Homelike Environment,' revised May 2017, states that the facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include:Clean, sanitary and orderly environment;Pleasant, neutral scents. Observations on Monday, May 11, 2026, at 9:30 am, on B-wing, room B16-1, revealed visibly soiled floor surface with accumulated dirt and condiments wraps, wall panel peeling and leak stains on two ceiling tiles. Further observation of C-wing unit revealed malodorous smell in room B-17. Further observations on B-wing revealed entrance doors to room B-19 to have dried food splatter, smudges, and accumulated dirt on surface. Further observations on B-wing revealed entrance doors to room B-21 to have dried food splatter, smudges, and accumulated dirt on surface. Further observations on B-wing revealed entrance doors to room B-23 to have dried food splatter, smudges, and accumulated dirt on surface as well as foul odor. Further observations of B-wing unit revealed entrance doors to room B-24 with dried food residue and food staining as well as dirt accumulation on door surface. Observations of C-wing unit on Monday, May 11, 2026, at 12:00 pm, revealed food debris in room C1-1. Further observations of C-wing unit revealed bedside table with visible dirt and accumulated dirt on floor surface. Further observation on C-wing unit revealed gnats in room C6-2 and pillowcase visibly soiled with dark discoloration. Observation was made on May 11, 2025 at 9:45 a.m. of the D-Wing unit. When walking onto the unit there were noticeable black and brown staining on the floors of the hallway. The same staining appeared in the D-wing dining room. Observation on May 11, 2026 of room [ROOM NUMBER] revealed room that smelled of urine. The resident had soiled sheets. The floor had paper trash and food particles all throughout. Interview held with the license practical nurse Employee EXX on May 11, 2026 at 12:00 p.m. revealed the resident in room [ROOM NUMBER] has behaviors and the facility does what they can with keeping the room clean. Observation on May 11, 2026 of room [ROOM NUMBER] revealed what appeared to be vomit on the floor in between the two resident beds. The dresser had colored liquid spills all over the side and front. Colored liquid spills were on the walls. One ceiling tile was stained. The Director of Housekeeping Employee E6 confirmed these findings on May 11, 2026 at 10:55 a.m. The Director of Housekeeping Employee E6 stated that he was new and still figuring out the building and what roles each housekeeping staff should have. Observation on May 11, 2026 of room [ROOM NUMBER] revealed the floor was soiled with colored stained and there was paper trash on the floor. Observation on May 11, 2026 of room [ROOM NUMBER] revealed baseboard wall falling off the wall on the left hand side when you walk into the room. There were three roaches traps in the room all had dead roaches in them. Observation on May 11, 2026 of the D-Wing unit hall bathroom revealed a toilet that was clogged and filled with feces. There was feces on the back of the toilet and on the floor surrounding the toilet. Around the heating unit by the bathtub the tile was seen peeling off. The sink was dirty and there were no paper towels located in the paper towel holder. These findings were confirmed at 12:17 p.m. with the Director of Housekeeping Employee E6. 28 Pa Code 201.14(a) Responsibility of licensee

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility documentation, and interviews with staff and residents, it was determined that the facility to implement its abuse policy related to investigation and protection of residents, and to immediately protect a resident involved in resident to resident sexual abuse for one of three residents reviewed (Resident R83).Findings include:Review of facility policy titled Abuse Prevention Program, review date March 2017, revealed as the Policy Statement Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Review of Resident R83's clinical record revealed that the resident was initially admitted to the facility on [DATE], with diagnoses of Major Depressive Disorder (severe, often recurring mood disorder marked by persistent feelings of low mood and loss of interest in pleasurable activities), hypertensive heart disease without heart failure (high blood pressure causing changes in the heart without heart's losing the ability to pump blood efficiently), and Type Two Diabetes Mellitus (impaired ability of the body to regulate blood sugar, caused by lack of sensitivity to or production of insulin). Review of Resident R83's Minimum Data Set (MDS - a federally required resident assessment completed at a specific interval) completed December 18, 2025, section C0500 BIMS (Brief Interview of Mental Status) revealed that Resident R83 had a BIMS score of 9, suggesting that Resident R83 has moderate cognitive impairment. Review of documentation submitted to the State Survey Agency on December 23, 2025 revealed an allegation of sexual assault made by Resident R83 (female) involving Resident R46 (male), BIMS score 14, suggesting no cognitive impairment, was reported to have occurred on December 20. 2025. Further review of documentation submitted to the State Survey Agency revealed that within this allegation, Resident R46 had entered Resident R83's room, lifted up her shirt, and started to suck on her breast. Continued review of documentation submitted to the State Survey Agency revealed a head to toe skin assessment was performed on Resident R83 following the incident, with no abnormal findings. Hourly safety checks were initiated, Representative Party and Attending Physician were notified, and Residents R83 and R46 were interviewed. Review of facility Investigation report of this incident revealed alleged victim Resident R83 told Nurse Aide, Employee E18, who told resident's Licensed Nurse, Employee E5, the latter who then filed a Grievance/Concern form with Social Services. Further review of facility's Investigation Report revealed written statements from Nurse Aide and Licensed Nurse for Resident R83 (Employees E18 and E5) that neither had seen Resident R46 enter Resident R83's room. The incident/grievance was deemed resolved by Social Services Director, Employee E3 on December 22, 2025, due to lack of witnesses, denial of accusations by Resident R46, and stated Resident R46 was re-educated to avoid all contact with Resident R83. Continued review of facility's Investigation Report revealed no statements from any other residents besides Resident R83 and R46 were included in the report. Statements from staff included Director of Nursing (DON) (Employee E2), who interviewed both involved residents, Resident R83's Nurse Aide (Employee E18), Resident R83's Licensed Nurse (Employee E5) and Social Services Director/Grievance Officer (Employee E3). Review of separate documentation submitted to the State Survey Agency on April 29, 2026, related to an incident that occurred approximately a week prior to that (estimated in report as April 21, 2026), revealed that female Resident R83 alleged that on this date, male Resident R46 entered her room and inappropriately touched her legs and breasts. The report continued by stating no injuries or abnormalities were found upon skin assessment. The report included that residents R83 and R46 were interviewed, the latter who denied the allegation. No other witnesses were identified, according to the report. The incident was reported to police and attending physician. Residents were separated and Resident R46 was instructed to have no contact with Resident R83, and Resident R83's room was (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changed from D wing (room D223-1) to C wing at her request. The report further states that staff were advised to uphold increased supervision and no-contact interventions between the two residents, including frequent staff rounding. Additionally, residents' Care Plans were updated accordingly, and alleged victim, Resident R83, was to continue to be monitored daily with hourly safety checks. Review of Resident R83's clinical records reveal no order (even discontinued or completed) for hourly safety checks. Review of Facility Investigation Report revealed written statement by Resident R83's nurse at the time of second incident, Employee E23, revealed Resident R83 told Resident R46 to stop and to leave her room, and he has not touched her again since this instance, however stated Resident R46, sits outside her [Resident R83's] room looking in, which makes her uncomfortable. Further review of facility Investigation Report revealed the DON, Employee E2, had interviewed Resident R83; Employee E2's written statement revealed Resident R83 told her the incident with male Resident R46 happened about a week ago but she had not reported it to anyone. Employee E2, in her statement, had responded to Resident R83 to scream for help and use your call bell if Resident R46 came to her room. Interview with DON, Employee E2 on May 13, 2026 at 1:11 PM confirmed this suggested intervention made to the alleged victim, Resident R83. Furthermore, she admitted that it would be difficult to confirm sexual abuse allegation from a skin check in both of these incidents, as there had been no alleged penetration/rape. Continued review of facility Investigation Report revealed only two staff interviews were included after the April 27, 2026 incident: from the DON, Employee E2, and from Resident R83's Licensed Nurse at the time of the incident, Employee E23. Employee E2 wrote in a separate statement within the Investigation Report, dated April 28, 2026, that the matter was considered resolved following an Interdisciplinary Team meeting held with Resident R46 and his brother post-incident, Resident R46's denial of having touched Resident R83 inappropriately but had admitted to going to her room, and Resident R83's room having been changed from the D wing to the C wing at her request. Interview with Resident R83 on May 13, 2026 at 10:49 AM revealed she and Resident R46 were friends before he started acting like that (in a sexual nature toward her) and that Resident R46 told her he wanted to touch her breasts and asked her if he could kiss her, she replied no and reiterated that she has a boyfriend to whom she is committed outside the facility. However, it was unclear if these statements were made by Resident R46 before the first or the second incident. Further interview with Resident R83 confirmed the incident involving sexual abuse by Resident R46 happened on or slightly before April 27, 2026. Resident R83 revealed she immediately slapped him and told him to leave and that she did not want to talk to him anymore (effectively ending their friendship), and he left. She stated she asked for a room change to a different wing, and that Resident R46 does not know where her room is now but she observes him passing by and looking into rooms, and other residents have told her he is looking for her. She said he saw her getting onto the elevator one day to go to an activity and that he said Where are you going? but she did not respond. Continued interview with Resident R83 revealed that during the first incident (December 2025), Resident R83's roommate was present, but that the roommate doesn't understand what's going on. Furthermore, per Resident R83's account, there were no witnesses during the second, most recent incident in April 2026. Review of clinical records revealed that Resident R83's former roommate, Resident R85 (room D223-2) has a BIMS score of 3, indicating severe cognitive impairment. Resident R85 was not interviewed by the facility. Further review of facility's Investigation Report revealed the facility unsubstantiated the event of April 27, 2026 based upon no witnesses to the incident, Resident R46's denial of accusation, no anomalies noted upon skin inspection, and lack of corroborating evidence. Interview with DON, Employee E2, on May 13, 2026 at 1:11 PM confirmed both of these instances of alleged sexual abuse made by Resident R83 against R46, and confirmed that both investigation reports had no documented interviews with residents other than the alleged perpetrator and victim. 28 Pa. Code 201.18(b)(3)(e)(1) Management28 Pa. Code 202.29(a) Resident rights28 Pa. Code 211.10(d) Resident care policies28 PA. Code 211.12(c) Nursing services

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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. Based on observations, review of facility policy and interview with staff, it was determined that facility did not ensure to develop and implement a resident centered care plan for one of 20 residents reviewed related to psychosocial health. (Resident R21)Findings include: Review of facility policy ?Comprehensive Person - Centered Care Plans,' revised December 2016, indicates that the comprehensive, person -centered care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable , physical mental, and psychosocial well-being and describe any specialized services to be provided as a result of Preadmission Screening and Resident review (PASARR) recommendations. Review of Resident R21's clinical record revealed medical history of schizophrenia (mental disease characterized by loss of reality contact), and cerebral infarction (stroke). Review of Resident R21's ?psychotropic medications review,' completed on March 10, 2026, revealed Resident R21 received the following medications for Schizophrenia: Risperdal 0.5 milligrams (mg), Depakote delayed release 500 mg and Depakote delayed release 250 mg, and Ziprasidone 8 mg. Review of Resident R21's Minimum Data Set (MDS), completed on March 23, 2026, revealed Brief Interview for Mental Status (BIMS) score of 9 which indicated that the resident had moderate cognitive impairment. Review of ?Senior Care Therapy,' evaluation, completed on March 27, 2026, by licensed marriage and family therapist, Employee E20, revealed that resident was assessed for display of symptoms of anxiety and depression related to adjustment to current life phase. Further review of ?Senior Care Therapy' evaluation prognosis and rationale revealed that Resident R21 presents with moderate depressive symptoms . (She/He) demonstrates insight and benefits from strong protective factors, including supportive adult children, engagement in activities, and daily spiritual practices. Further review of ?Senior Care Therapy' evaluation revealed treatment goals related to adjustment to change in life phase, sadness, difficulty coping with medical issues. Observations during day shift on Monday, May 11, 2026, on B-wing unit, revealed Resident R21 anxiously moving around the day room in wheelchair. Interview with nurse aide, Employee E12, on Monday, May 11, 2026, at 11:00 am, who was assigned to supervise residents in day room on B-wing, revealed that Resident R21 has a type of dementia and anxious behavior is typical - specifically, requesting to be out of bed and placed back in bed continuously throughout shift. Review of Resident R21's nursing notes dated May 13, 2026, at 4:27 pm, revealed she was observed to be crying, restless and confused, distressed when placed in wheelchair and consistently requesting to be placed back in bed. Once resident was in bed (she/he) wants to get out of bed once in bed. Further review of nursing notes dated May 13, 2026, at 9:56 pm, revealed that Resident R21 was observed crying to go to bed, and after a while was observed attempting to get out of bed. Review of Resident R21's care plan revealed no goals or interventions developed related to psychosocial behaviors. 28 Pa Code 211.10 (c) (d) Resident care policies28 Pa Code 211.12 (d)(1)(3)(5) nursing services

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews with staff, and review of facility documentation it was determined that the facility did not ensure to update and implement a comprehensive centered care plan related to behaviors for one of twenty residents reviewed. (Resident R46)Findings Include: Review of the facility policy titled, Care Plans, Comprehensive Person-Centered last revised December 2016 states, Policy Statement- A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Further review of the facility policy states, g. Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems. Review of facility documentation revealed Resident R46 was admitted to the facility on [DATE] with the following diagnosis: Type Two Diabetes (a chronic condition where your body either resists the effects of insulin or doesn't produce enough to maintain normal glucose levels), Bi-Polar Disorder (a mental health condition characterized by extreme, cyclical shifts in mood, energy, and activity levels), Hypertension (a chronic condition in which the force of blood against your artery walls is consistently too high), Kidney Disease (your kidneys are damaged and cannot filter blood properly), Acquired absences of the left and right leg above the knee, and Insomnia (a common sleep disorder characterized by difficulty falling asleep, staying asleep, or waking up too early and struggling to go back to sleep). Review of facility documentation revealed Resident R83 was admitted to the facility on [DATE] with the following diagnosis: Major Depressive Disorder (a serious mood disorder characterized by pervasive low mood and loss of interest), Hypertensive Heart Disease (structural and functional heart damage caused by chronic, uncontrolled high blood pressure), Osteoarthritis (the most common form of arthritis), Hyperlipidemia (high levels of lipids (fats), such as cholesterol and triglycerides, in the blood), and Type Two Diabetes (a chronic condition where your body either resists the effects of insulin or doesn't produce enough to maintain normal glucose levels). Review of facility documentation revealed a Grievance/Concern form completed on December 20, 2025 and signed by licensed nurse Employee E5, That man Resident R46 came into my room lifted up my shirt and put his mouth on my breast. Resident R83 said the incident happened today. Review of facility documentation revealed a statement from licensed nurse Employee E5 that stated, On Saturday December 20, 2026 I was the charge nurse on 7 a.m.- 3p.m on the second floor D-Wing. I was called to room D23 by the nurse aide on that assignment in reference to resident R83. Resident stated, Resident R46 came into my room yesterday and lift up my shirt and put his mouth on my breast. Full head to toe assessment complete skin intact with no bruising, bleeding or any issues noted. I did not witness Resident R46 go into Resident R83's room. Review of Resident R46's care plan revealed a care plan update on December 24, 2025 with one intervention Re-educated to stay away from resident (Resident R83) Resident R46's care plan included no mention of inappropriate behavior. Review of Resident R46's clinical record revealed a Behavioral Assessment completed on March 20, 2026 that lists Identified Behavioral Symptoms as, yelling/repetitive verbalizations, agitation/irritability or hyperactivity, and verbal aggression. Further review of the assessment revealed Seriousness of the Behavioral Symptom- Patient is immediate threat to others -immediate intervention required is checked of as YES. Further review of the assessment reads Additional comments- just angry for no reason will not listen to re-direction. Review of the resident's care plan revealed no goals or interventions added on March 20, 2026. According to the two facility reported incidents. The resident was accused of sexual abuse against another resident in December 2025 and again in April 2026. An interview was held with the Nursing Home Administrator Employee E1 and the Director of Nursing Employee E2 on May 13, 2026 at 2:00 p.m. to discuss the facility reported incidents. The Director of Nursing Employee E2 explained that Resident R46 refused to change rooms/floor after the sexual (continued on next page)

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	395764	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Center for Rehabilitation and Nursing	7310 Stenton Avenue Philadelphia, PA 19150

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assault allegation in April 2026. Therefore, the other resident was moved and Resident R46 was instructed not to go on C-Wing unit past room C3. During an observation on May 12, 2026 at 11:45 a.m. resident R46 was seen ambulating in his/her wheelchair down the hall past resident room C3. When Resident R46 was re-directed by staff he/she became verbally aggressive stating, I pay here, I don't care what they say, If they tell me what to do, put me out, I pay for this, put me out. I pay for this I don't care, put me out The resident was re-directed to in front of his/her room. An interview was held with licensed Nurse Employee E5. Employee E5 did state that he/she was aware of Resident R46 not being allowed past resident room C3 due to the previous incident with two female residents. Interview held with Employee E5 revealed, Resident R46, you can't tell him/her anything, he/she does that all the time. Resident R46 will spit, throw things, curse you out, throw things at you, and will physically attack staff. When asked if the Resident was easily re-directed, the licensed nurse Employee E5 confirmed that the resident becomes easily agitated and is not easily re-directed with staff. The licensed nurse Employee E5 was asked what else the staff does besides re-direction and Employee E5 stated that was it. Interview was held with the Director of Nursing Employee E2 on May 12, 2026 at 2:10 p.m., who confirmed there could have been more goals and interventions added after the first incident investigations. 28 Pa. Code 201.18 (b)(1)(3)(e)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12 (d)(1)(2)(5) Nursing services

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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. Based on observations, review of clinical records and review of facility policy, it was determined that facility did not ensure to provide activities of daily living (ADL's) assistance for two of 20 residents reviewed (Residents R34, R41)Findings include: Review of facility policy ?Activities of Daily Living Support,' revised March 2018, indicates that residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.Further review of policy revealed that appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with plan of care, including appropriate support and assistance with:Hygiene (bathing, dressing, grooming, and oral care)Elimination (toileting) Review of Resident R34's clinical record revealed medical history of need for assistance with personal care, schizophrenia (mental disease characterized by loss of reality contact), lack of coordination, muscle weakness, gait and mobility abnormalities, leukemia (a type of cancer that affects the blood and bone marrow). Review of Minimum Data Set (MDS) completed on May 7, 2026 revealed Resident R34's brief interview for mental status (BIMS) score of 3, which indicated that the resident was cognitively impaired. Further review of Resident R34's MDS revealed he requires partial/moderate assistance with toileting and hygiene care. Further review of Resident R34's MDS revealed he is frequently incontinent of bowel and bladder. Review of Resident R34's care plan revealed interventions to check Resident R34 as needed and as required for incontinence care, change clothing as needed after incontinence episode. Review of Resident R41's clinical record revealed medical history of need for assistance with personal care, bell's palsy, cerebral infarction, gait and mobility abnormalities, muscle weakness, aphasia, fall. Review of Minimum Data Set completed on February 12, 2026 revealed Resident R41's brief interview for mental status (BIMS) score of 12, which indicated that the resident was cognitively intact. Further review of Resident R41's MDS revealed he requires supervision or touching assistance with toileting and hygiene care. Review of Resident R41's care plan revealed interventions to check R41 as needed and as required for incontinence care, change clothing as needed after incontinence episode. Observations on Monday, May 11, 2026, at 11:05 am, on C-wing unit, revealed Resident R34 wearing a hospital gown, ambulating alone from room C-12 to emergency eye wash station room with brief observed to be heavily saturated with urine and overflowing on to the floor. Further observation on C-wing unit, at 11:35 am, revealed Resident R41 sitting in wheelchair on hallway with soiled from urine clothing. 28 Pa Code 211.10(d) Resident care policies28 Pa Code 211.12(d)(1)(5) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview with resident, review of clinical records, review of facility policy and facility provided documentation, it was determined that facility did not ensure to provide adequate supervision to prevent an accident for two residents and one employee (Resident R7, R46, and Employee E19)Findings include: Review of facility policy ?Abuse Prevention Program,' revised December 2016, indicates that as part of the resident abuse prevention, the administration will develop and implement policies and procedures to aid our facility in preventing abuse, neglect or mistreatment of our residents. Review of facility policy ?Behavioral Assessment, Intervention and Monitoring,' revised December 2016, indicates that the interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. Further review of policy indicated that safety strategies will be implemented immediately if necessary to protect the resident and others from harm. Review of Resident R7's clinical record revealed medical history of psychoactive substance abuse, bipolar disorder (mental health condition characterized by extreme mood swings), depression (major loss of interest in pleasurable activities), and paraplegia (paralysis of the legs and lower body). Review of Resident R7's Minimum Data Set completed on March 16, 2026, revealed Brief Interview for Mental Status (BIMS) score of 15, which indicated that the resident was cognitively intact. Review of Resident R46 clinical record revealed medical history of acquired absence of bilateral legs above knees, bipolar disorder, syphilis (sexually tramsmitted infection). Review of Resident R46's Minimum Data Set completed on March 23, 2026, revealed Brief Interview for Mental Status (BIMS) score of 15. Further review of Resident R7 clinical record revealed that on June 9, 2025, there was an altercation between Resident R7 and Resident R46. Altercation between both residents was related to stolen money and broken phone. The altercation occurred in Resident R7's room and both residents had to be separated. Resident R46 became verbally threatening towards Resident R7 and towards staff. Further review of nursing progress notes revealed that Resident R46 became increasingly agitated, continued to yell, cursing staff who was attempting to calm (him/her) down. Further review of nursing progress notes, dated June 19, 2025, at 2:27 pm, revealed that Resident R7 expressed verbal aggression towards staff. Further review of nursing progress notes, dated June 21, 2025, at 12:53 pm, revealed another altercation between Resident R7 and Resident R46; two staff members witnessed Resident R46 leaving Resident R7's room after allegedly pulling (her/his) cover off and throwing (her/his) personal belongings on the floor. Resident R7 called the police and was informed on instruction for how to apply for a protection/restraining order against Resident R46. Further review of nursing progress notes, dated June 27, 2027, at 11:01 pm, revealed that R7 reported again R46 entered her room and started hitting her in back section. Staff member who witnessed the incident separated them, took resident aggressor to the nurse's station. As he was angry, he was trying to go back on C-wing to physically aggress R7, he held on the rail, his chair tilted back, he fell on his back. Interview with Resident R7 on May 13, 2026, at 11:00 am, indicated that she does not feel safe at the facility due to continuous harassment by Resident R46. Review of facility provided ?investigation of alleged abuse, neglect, misappropriation of property,' revealed that another altercation occurred between Resident R7 and Resident R46 on March 31, 2026, at 10:15 pm. Assigned nurse aide, Employee E19, heard commotion coming from room C3 and observed Resident R7 lying in (her/his) bed and R46 sitting in wheelchair hitting Resident R7 with a grabber. Further review of investigation report revealed that both residents were separated and Resident R46 started attacking the staff and in the process of trying to hit staff, Resident R46 fell out of the wheelchair face down to the floor. Resident R46 sustained an open area under 9his/her) left eye, a bump to the forehead. Resident R7 also sustained skin tear to the right knee. Interview with facility's Director of Nursing, Employee E2, on Thursday, May 14, 2026, at 1:00 pm, revealed that Nurse aide (Employee E19) is currently on leave of (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	absence due to injured finger resulting from incident on March 31, 2026. 28 Pa Code 201.18 (b)(1) Management 28 Pa Code 211.10 (d) Resident care policies 28 Pa. Code 211.12(d)(10(5) Nursing services

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of resident clinical records, observations, and staff interviews, it was determined that the facility did not ensure a resident received appropriate behavioral health management to maintain the highest practicable well-being for one of twenty residents reviewed (Resident R46).Findings Include: Review of facility policy titled, Behavioral Assessment, Interventions and Monitoring last revised December 2016 states, Policy Interpretation and Implementation- General Guidelines 1. Behavior is the response of an individual to a wide variety of factors. These factors may include medical, physical, functional, psychosocial, emotional, psychiatric, or environmental causes. Further review of the policy states, Assessment.3. The nursing staff will identify, document, and inform the physician about specific details regarding changes in an individual's mental status, behavior, and cognition, including: a. Onset, duration, intensity and frequency of behavioral symptoms. 4. New onset or changes in behavior will be documented regardless of the degree of risk to the resident or others. Review of facility documentation revealed Resident R46 was admitted to the facility on [DATE], with the following diagnosis: Bi-Polar Disorder, (condition in which the person has periods of depression and periods of being extremely happy) acquired absences of the left and right leg above the knee, and insomnia (unable to fall asleep). According to the two facility reported incidents, the resident was accused of sexual abuse in December 2025 and again in April 2026. An interview was held with the Nursing Home Administrator Employee E1 and the Director of Nursing Employee E2 on May 13, 2026 at 2:00 p.m. to discuss the facility reported incidents. The Director of Nursing Employee E2 explained that Resident R46 refused to change rooms/floor after a sexual assault allegation in April 2026. Therefore, Resident R46 was instructed not to go on C-Wing unit past room C3. During an observation on May 12, 2026 at 11:45 a.m. Resident R46 was seen ambulating in (his/her) wheelchair down the hall past resident room C3. When Resident R46 was re-directed by staff (he/she) became verbally aggressive stating, I pay here, I don't care what they say, If they tell me what to do, put me out, I pay for this, put me out. I pay for this I don't care, put me out The resident was re-directed to in front of (his/her) room. An interview was held on May 12, 2026 at 11:47 a.m. with Licensed Nurse Employee E5. who stated that he/she was aware of Resident R46 not being allowed past resident room C3 due to the previous incident with two female residents. Interview held with Employee E5 revealed, Resident R46, you can't tell him/her anything, he/she does that all the time. Resident R46 will spit, throw things, curse you out, throw things at you, and will physically attack staff. When asked if the Resident was easily re-directed, the licensed nurse Employee E5 confirmed that the resident becomes easily agitated and is not easily re-directed with staff. The licensed nurse Employee E5 was asked what else the staff does besides re-direction and Employee E5 stated that was it. Review of Resident R46's nursing progress notes revealed no documentation of behaviors or causes for behaviors. There was not enough evidence to show that nursing staff was identifying, documenting, and informing the physician about specific details regarding changes in Resident R46's mental status and behavior including; onset, duration, intensity, and frequency of behavioral symptoms. Further review of the psychological progress notes revealed a note from April 9. 2026 that stated: Follow up recent altercation of this patient with another patient. Patient stated, I am not allowed to talk about incident. Mood and behavior at baseline, Denies depression or anxiety. No reported changes to sleep, energy, or appetite. Nursing staff offered no concern at this time Review of Resident R46's psych progress notes from 2025 all revealed, Nursing staff offered no concerns at this time for every visit. The above findings were confirmed with the Director of Nursing on May 14, 2026 at 1:00 p.m. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management28 Pa. Code 211.12(c)(d)(3) Nursing services

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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 observation and staff interview, facility did not ensure proper storage of controlled substance medications for 1 of 2 medication rooms. (1st Floor)Findings Include: Observation on May 13, 2026 at 10:15 AM of the 1st floor medication room revealed only medication cart nurses and the Director of Nursing (DON), Employee E2, have keys to the medication room and to the medication room's refrigerator, with controlled substances stored inside a separate box within the refrigerator. Further observation revealed drawer containing controlled substances inside the refrigerator lacked permanent affixing to the refrigerator and was able to be removed from the refrigerator. Interview with the Director of Nursing (DON), Employee E2, at the time of observation revealed her statement that only the nurses and I (DON) have access to the controlled substances and it was due to the fact that the inside shelf was made of glass. Further interview with the DON, Employee E2, at this time revealed her confirmation that this would not prevent staff diversion. 28 Pa. Code 211.9 Pharmaceutical services 28 Pa. Code 211.12 Nursing services

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the facility assessment and staff interviews, it was determined that the facility did not ensure active involvement of direct care staff and input from residents, resident representatives, and family members in the development and revision of the facility assessment. Additionally, the facility failed to identify within the facility assessment an accurate resident population with mental health and substance abuse diagnosis. Findings include:Review of facility policy ?Facility Assessment,' updated July 14, 2025, states that the purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. The assessment is used to make decisions about direct care of staff needs, as well as capabilities to provide services to the residents in facility. The facility assessment is used to ensure that each resident is provided with care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being. Further review of the facility assessment dated [DATE] included only three members completing the assessment. The three members included were the Nursing Home Administrator, Director of Nursing Employee, and one other staff. The resident assessment did not include involvement of direct care staff, or input from residents or resident representatives. This was confirmed on May 14, 2026 at 10:15 a.m. with the Director of Nursing Employee E2.Further review of the resident assessment included Special Treatments and Conditions- Mental Health- Behavioral Health Needs- 0-1 was listed as the number/average or range or residents. For Active or Current Substance Use Disorders- 1-3 was listed as the number/average or range residents. The facility assessment revealed that facilities must review and update assessments yearly or whenever resident care needs change significantly (e.g., admitting residents needing ventilators or dialysis), ensuring staffing, resources, environment, training, and supplies can meet those needs. Further review of facility assessment, under ?special treatments and conditions, revealed that facility has 0-1 residents with behavioral health needs and 1-3 residents with active or current substance use disorder.Review of clinical record for Resident R3 revealed medical diagnosis of schizophrenia, and depression. Review of clinical record for Resident R62 revealed medical diagnosis of severe intellectual disabilities, mood disorder, restlessness and agitation, psychotic disorder with delusions, autistic disorder. Review of clinical record for Resident R60 revealed medical diagnosis of bipolar disorder, diffuse traumatic brain injury, intellectual disabilities, alcohol abuse, cannabis use. Review of clinical record for Resident R21 revealed medical diagnosis of schizophrenia. Review of clinical record for Resident R4 revealed medical diagnosis of post traumatic stress disorder, schizophrenia, anxiety disorder. Review of clinical record for Resident R71 revealed medical diagnosis of Huntingdon's disease, schizophrenia, major depressive disorder. Review of clinical record for Resident R68 revealed medical diagnosis of paranoid schizophrenia, major depressive disorder. Review of clinical record for Resident R7 revealed medical diagnosis of bipolar disorder, depression, psychoactive substance abuse, opioid dependance with opioid-induced mood disorder. Review of clinical record for Resident R9 revealed medical diagnosis of schizophrenia, anxiety disorder. Review of clinical record for Resident R47 revealed medical diagnosis of schizophrenia, major depressive disorder. Review of clinical record for Resident R73 revealed medical diagnosis of schizophrenia. Review of clinical record for Resident R29 revealed medical diagnosis of schizoaffective disorder, depression. Review of clinical record for Resident R6 revealed medical diagnosis of schizophrenia. Review of clinical record for Resident R61 revealed medical diagnosis of alcohol abuse, alcohol dependance with alcohol-induced persisting dementia. Review of Resident R1 clinical record revealed a diagnosis of Psychoactive Substance Abuse ((is a medical condition characterized by an impaired ability to stop or control cocaine use despite adverse social, occupational, or health consequences) (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Depression (a common, treatable mood disorder characterized by persistent sadness, loss of interest, and physical symptoms like fatigue or sleep changes). Review of Resident R23 clinical record revealed a diagnosis of Cocaine Abuse (is a medical condition characterized by an impaired ability to stop or control cocaine use despite adverse social, occupational, or health consequences) and Alcohol Abuse (is a medical condition characterized by an impaired ability to stop or control alcohol use despite adverse social, occupational, or health consequences). Review of Resident R25 clinical record revealed a diagnosis of Alcohol Abuse (is a medical condition characterized by an impaired ability to stop or control alcohol use despite adverse social, occupational, or health consequences). Review of Resident R32 clinical record revealed a diagnosis of Schizoaffective Disorder (a chronic mental health condition characterized by a combination of schizophrenia symptoms like hallucinations or delusions and mood disorder symptoms like depression or mania). Review of Resident R44 clinical record revealed a diagnosis of Anxiety (a group of mental health conditions that cause persistent, excessive, and uncontrollable fear or worry that interferes with daily activities) and Schizophrenia (a chronic brain disorder characterized by disruptions in thought processes, perceptions, and emotional responsiveness). Review of Resident R46 clinical record revealed a diagnosis of Bipolar Disorder (a mental health condition characterized by extreme, cyclical shifts in mood, energy, and activity levels). Review of Resident R53 clinical record revealed a diagnosis of Bipolar Disorder (a mental health condition characterized by extreme, cyclical shifts in mood, energy, and activity levels). 28 Pa. Code S 201.18(b)(3) Management.