STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395801	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quadrangle	3300 Darby Road Haverford, PA 19041

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923 Based on review of facility policy, clinical record, facility documentation, and interviews with staff, it was determined the facility failed to check the temperature of the hot water provided to Resident R1 which resulted in actual harm to Resident R1, of spillage of hot water on the left upper and outer thigh, and developing a blister on the left thigh for one of six residents. (Resident R1) Findings include: Review of the facility's police title Safe holding and serving temperature for hot beverages last revised May 2, 2017, revealed the temperatures that hot beverages should be served at are governed by palatability and by the risk for a burn. Under Procedure A, it further states Serve the hot beverages between 140 and 155 degrees. Dietary should record hot beverage temperatures for every meal. Review of information dated December 24, 2024 and submitted to the State Survey Office on December 24, 2024, indicated, After having dinner on 12/23/2024 at 6:00 p.m. [Resident R1] was enjoying a cup of hot tea. She/he was putting sugar in the teacup and attempting to stir it in when the tea spilled onto her lap. [Resident R1] is independent with feeding. [Resident R1]spilled the cup of tea on [his/her] lap, the tea hit [his/her] left upper inner thigh area. Continued review of the report revealed Liquids temperatures are logged for each meal, The hot beverage temperature for the tea that was logged on 12/23/24 evening was at 139 degrees. Resident R1 does not require adaptive feeding utensils. Review of Resident R1's clinical record revealed an admitted [DATE]. Review of the Minimum Data Set assessment (MDS - periodic assessment of resident care needs) dated December 21, 2024, revealed a Brief Interview for Mental Status (BIMS) of 15 which indicated the resident was cognitively intact. Review of the Resident R1's occupational therapy assessment dated [DATE], indicated Resident R1 was independent with eating. Review of Resident R1's clinical nursing note documented on December 23, 2024, at approximately 10:12 p. m. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	after having dinner [Resident R1] was enjoying a cup of hot tea. [Resident R1] spilled a cup of tea on [his/her] lap. Hitting [her/his] left upper inner thigh area. Supervisor on duty went to assist resident and applied a cool compress. About 45 minutes later nurse went into check on resident and notice blisters on the area. Physician was notified and prescribed Silvadene. Review of the clinical nursing note documented by the Assistant Director of Nursing, Employee E12 on December 24, 2024, revealed [Resident R1] seen by this nurse and NP (Nurse Practitioner) seen resident and assessed burns [she/he] sustained last night from spiling hot tea. Left upper and outer thigh noted with redness and open blister to inner left thigh, 14 cm x 10 (centimeter) cm. No drainage noted, deep redness 8x2 cm on outer thigh. NP ordered to continue Silvadene to area. Review of the facility's investigation revealed a written statement from Nurse Aide, Employee E4, which indicated On 12/23/24 I take care of [Resident R1]. Around 5:00 p.m. dietary passed dinner trays and Resident R1 got hot water in the tray but no tea bag and no sugar. Resident R1 ring the bell and I went in room to help [her/him]. Resident R1 ask [her/him] for tea bag and sugar. I ask dietary girl, [Employee E5] to bring it. Employee E5 bring another hot water in red mug and tea bag and sugar. [Resident R1] was mixing sugar when the tea fell on [her/him]. I heard [Resident R1] screaming and ring the call bell. I took [her/his] pants off and gave [her/him] cold wash cloth and let the supervisor know. An observation of the hot water dispenser and an interview was conducted on January 16, 2025, at 10:14 a.m. with the Dietary Manager, Employee E3 and Nursing Home Administrator, Employee E1. During the interview Dietary Manager, Employee E3 measured the hot water dispenser temperature at 140 Fahrenheit (F). Dietary Manager, Employee E3 explained that the facility's protocol for serving hot beverages was for the hot beverage to be poured into a cup approximately 10 minutes before the serving line is prepared, and its holding temperature is measured. While the beverage cools, the serving line is prepped. Once the serving line is ready, the beverage temperature is measured again to ensure it is within the safe range of 140 F or below. Only then is the beverage placed on the resident's tray. Review of the temperature log sheet for the dinner meal on December 23, 2024, indicated the serving temperature of the hot beverage tea dispenser was documented at 135 F. Dietary Manager, Employee E3 further explained that Resident R1 resided on the first floor, while the kitchen, where the food was prepared, was located on the second floor. Resident R1 consistently ate all meals in [her/his] room. Consequently, on December 23, 2024, Resident R1's meal was placed in a food truck and delivered directly to [her/his] room. When Resident R1 requested sugar or a tea bag from Nurse aide, Employee E4, the standard protocol was for the staff to notify the kitchen. The kitchen staff would then deliver the missing items to the resident's room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On January 16, 2025, at 11:35 a.m., a telephone interview was conducted with Dietary aide, Employee E5, who served the hot beverage to Resident R1 on December 23, 2024. During the interview Dietary aide, Employee E5 confirmed that she had received a call from Nurse aide, Employee E4, reporting that [Resident R1] was missing either a hot tea bag or a cup of hot water. During the interview, Dietary manager, Employee E3 entered the room while interview was being conducted with documents for the surveyor. The surveyor requested that Dietary manager, Employee E3 remain for the rest of the phone interview with Dietary aide, Employee E5. Employee E5 was informed that Dietary manager, Employee E3 would be joining the conversation. Dietary aide, Employee E5 disclosed that when asked to assist the resident, she went to the kitchen, took an empty cup, and poured hot water from the hot water dispenser. When the surveyor inquired whether she measured the temperature of the hot water, Dietary aide, Employee E5 admitted , No. She further revealed that, prior to this incident, she had not been measuring the temperatures of hot beverages. However, following the incident, all staff members were educated on proper procedures and now measure the temperatures of hot beverages to ensure safe handling. Dietary manager, Employee E3, confirmed the hot water provided to Resident R1 by Dietary aide, Employee E5 had not been checked to verify if it was at safe serving temperature. On January 16, 2025, at 11:41 a.m., the lunch meal service was observed with Dietary Manager, Employee E3. The temperature of the hot water dispenser was measured prior to serving lunch and recorded at 169.5 F holding temperature. On January 16, 2025, at 11:45 a.m., four dietary aides-Employees E6, E7, E8, and E9 independently were interviewed and reported that they had all been retrained to measure temperatures to ensure hot foods are at 140 F or below before being placed on residents' trays. An interview with the Administrator, Employee E1 on January 16, 2025, at 12:03 p.m. confirmed the Dietary aide Employee E5 did not check the hot water temperature to verify if it was at a safe temperature, which resulted in Resident R1 receiving a burn. The facility failed to check the temperature of the hot water provided to the Resident R1 which resulted in actual harm to Resident R1, spilling a hot water cup on her/his left upper and outer thigh, and developing a blister on the left thigh measuring and deep redness on the outer thigh. 28 Pa. Code 211.10(c)(d) Resident Care Policies 28 Pa. Code 211.12(d)(1)(5) Nursing Services

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923 Based on observation, clinical record review, review of select manufacture's guidelines, and staff interview, it was determined that the facility failed to ensure a medication error rate of less than 5 percent for 1 out of 2 residents reviewed. (Resident R3). Findings include: The facility's policy title Medication Administration General Guidelines revised 2027 states Medications are administered as prescribed in accordance with manufactures' specification, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. The facility's New Admission Checklist policy unknown creation date, reveals Prior to admission, enter allergies into system, put in ancillary orders see separate sheet/documents; save in queue, pt (patient) in medication order save in queue, add diet order in queue, add code status, verify orders with assigned doctor/NP (nurse practitioner). Review of Resident R3's clinical record revealed that the resident was admitted to the facility on [DATE] with the following diagnoses of COVID-19, Pneumonitis (inflammation of the lungs tissue) due to inhalation of food and vomit, hypothyroidism (is a condition in which the thyroid gland does not produce enough thyroid hormones to meet the body's needs), hypertension (high blood pressure). Review of facility documentation reported to the State Survey Agency on January 16, 2025 stated [Resident R3] was admitted to the facility on [DATE], at 4:25 p.m. Medication were confirmed with[license nurse, Employee E13]. On the early morning of January 15, 2025, a nursing aid notified [nursing supervisor, Employee E14] that she was unable to obtain pulse ox (oxygen level) for [Resident R3]. [Employee E14] was not able to obtain pulse ox using 3 different devises. Skin turgor was noted as poor, capillary refill was 6 and respiratory rate was 10. Physician was notified and ordered [Resident R3] to be send back to the hospital. 911 was called. EMTs(Emergency Medical Technicians) noted resident with pulse ox of 505 on 6 liter of O2 (oxygen) and transferred [Resident R3] to the hospital at 7:00 a.m. on January 15, 2025. When pharmacist in the hospital reviewed [Resident R3] medications it was noted that the medications list provided by the facility was inaccurate. Upon further investigation at 10:20 a.m. on January 15, 2025 it was noted that Assistant Director of Nursing, ADON [Employee E12] had input medications were given the evening of January 14, 2025 that were prescribed for another new admission [Resident R4] into [Resident R3] profile. The following medication were given the evening of January 14, 2025 that were not prescribed for [Resident R3]: gabapentin 300mg (milligrams), melatonin 3mg. The following medications were not given the evening of January 14, 2025 as prescribed: aspirin 81 mg, Eliquis 2.5 mg, atorvastatin 40mg, metoprolol tartrate 25 mg, mirtazapine 7.5, and senna 8.6mg. Resident R3 has the following allergies: codeine, diphenhydramine, diphtheria Toxoid/Tetanus Toxoid, hydrochlorothiazide, Losartan, Penicillin, Benadryl, tetanus Toxoids, Coffee, Lavender, Peppermint, Rosemary, eucalyptus. [Resident R3] was noted with shortness of breath, respiratory ecidosis, right greater than left pleural effusion with bibasilar airspace opacities during her ER (emergency room) visit. [Resident R3] was discharge from the hospital to daughter's care the evening of January 15, 2025. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing, Employee E2, conducted on January 16, 2025, at 1:32 p.m., confirmed the medication error. The facility suspended the Assistant Director of Nursing (ADON), Employee E12, who provided a statement acknowledging that the error was hers. The resident's family was notified, and they did not believe that Resident R3 experienced an allergic reaction to the gabapentin or melatonin, as Resident R3 had no history of allergies to those medications. Review of the hospital discharge documentation revealed that Resident R3 was in the hospital due to Sepsis due to COVID-19 virus. Required ICU (Intensive Care Unit) for pressors and escalation oxygen. This history provides evidence that Resident R3 had history of respiratory concerns. An interview with Nursing Home Administrator, Employee E1, and Director of Nursing on January 16, 2025, at 2:45 p.m. revealed that the facility failed to provide medications that were specifically ordered for Resident R3. 28 Pa. Code 211.10(a) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services