

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395801	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/03/2025
NAME OF PROVIDER OR SUPPLIER  Quadrangle		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>39344</p> <p>Based on clinical record reviews, review of facility documentation and interviews with staff, it was determined that the facility failed to ensure that a resident was informed of charges for services not covered under Medicare, for one of three residents reviewed (Resident R61).</p> <p>Findings include:</p> <p>Clinical record review for Resident R61 revealed a social services note, dated October 14, 2024, at 3:18 p.m. which indicated that the resident was issued a NOMNC (Notice of Medicare Non-Coverage) with a last cover date of October 17, 2024. The note indicated that either discharge or alternate payor was due after that date.</p> <p>Continued review of social services notes for Resident R61 revealed a note, dated October 18, 2024, at 2:52 p.m. which indicated that the resident would discharge to an assisted living facility on October 21, 2024.</p> <p>Review of Resident R61's census data revealed that on October 17, 2024, the resident's Medicare A coverage ended and that on October 18, 2024, the resident paid out-of-pocket (privately paid) for skilled services until October 21, 2024, when the resident discharged from the facility.</p> <p>Continued review of facility documentation for Resident R61 revealed that the resident/resident's responsible party was not notified of the costs for skilled care after Medicare A coverage ended. Costs of care, as well as the election to receive those services, are required to be provided, in writing, on a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN).</p> <p>Interview on April 2, 2025, at 9:28 a.m. with Employee E7, Social Services Coordinator, revealed that Resident R61's responsible party should have been issued a SNF ABN, since the resident stayed at the facility and continued to receive skilled services that were paid for out-of-pocket. Employee E7, Social Services Coordinator, confirmed that Resident R61's responsible party did not receive the notice as required.</p> <p>28 Pa Code 201.18(b)(2) Management</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 395801
		If continuation sheet Page 1 of 22

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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>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>39344</p> <p>Based on review of facility policies, clinical record reviews, review of facility documentation and interviews with residents and staff, it was determined that the facility failed to ensure that residents were free from abuse and neglect for two of 25 residents reviewed (Residents R16 and R57).</p> <p>Findings include:</p> <p>Review of facility policy, Abuse, Neglect and Exploitation - Prevention, Reporting and Investigation dated revised February 14, 2022, revealed, Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Continued review revealed, Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Further review revealed, Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.</p> <p>Interview on March 31, 2025, at 12:31 p.m. Resident R16 stated that there was an incident with a nurse a few weeks ago; his pain pill fell , the pill got lost and the nurse refused to replace the pain pill.</p> <p>Review of Resident R16's care plan, dated initiated November 22, 2024, revealed that, The resident is on pain medication therapy related to osteomyelitis (bone infection) with a goal that the resident will be free of pain.</p> <p>Review of facility documentation submitted to the Pennsylvania Department of Health on March 11, 2025, at 9:38 p.m. revealed, Resident and family allege that on March 10, 2025, [Employee E17, licensed nurse] attempted to administer a requested oxycontin pill [opioid pain medication] to resident but it dropped. Staff looked for it without success. Nurse did not provide replacement med.</p> <p>Review of progress notes for Resident R16 revealed a nurses note, written by Employee E17, licensed nurse, on March 10, 2025, at 10:40 p.m. which stated, This nurse received notification that resident was in need of pain medication and when given the medication was dropped. This nurse and nursing supervisor went in to locate the lost pill without success.</p> <p>Continued review of progress notes for Resident R16 revealed a nurses note, written by Employee E18, licensed nurse, on March 10, 2025, at 11:58 p.m. which indicated that Resident R16 complained of not receiving his oxycodone at 10:00 p.m. due to it dropping on the floor during administration . Resident stated that he was not offered a replacement at that time . He complained of pain 8/10 [numeric pain scale, score of 8 indicates severe pain] . This nurse called the nurse who was on duty at the time and it was confirmed that resident did not receive his oxycodone at 10:00 p.m. due to it dropping on the floor and its inability to be located.</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>Review of facility documentation related to the event revealed a statement, written by Employee E17, licensed nurse, dated March 11, 2025, which stated, This nurse was told by staff that [Resident R16] needed pain medication. The resident received the medication but dropped it due to hand tremors. I stopped to look for the medication but was unsuccessful . I left the room and did not return because I was very uncomfortable by then the shift was over and I went home.</p> <p>Review of facility documentation related to the event revealed a statement, written by Employee E19, licensed nurse, dated March 18, 2025, which stated, On March 10th [Employee E17, licensed nurse] came and ask me to help her locate a pill that the resident drop while attempting to take it . After searching for a while we came to the conclusion that the pill was lost - so we wasted the pill. And I suggested to re check the severity of his pain and give him Tylenol to take the edge off until he was due again.</p> <p>Review of Resident R16's Controlled Drug Record for oxycodone 5 m.g (milligram) tablets revealed that on March 10, 2025, at 10:00 p.m. that one tablet was wasted by Employees E17 and E19, licensed nurses.</p> <p>Review of Resident R16's Medication Administration Record (MAR) for March 2025, revealed that on March 10, 2025, that the resident received a dose of oxycodone 5 m.g at 12:56 p.m. for pain 9/10 (severe pain) and that the next dose was administered at 11:45 p.m. for pain of 8/10 (severe pain) by Employee E18, licensed nurse. Continued review revealed that there was no indication on the Medication Administration Record that any doses were administered by Employee E17, licensed nurse, on March 10, 2025.</p> <p>Review of facility documentation, Report Form for Investigation of Alleged Abuse, Neglect, Misappropriation of Property, dated submitted April 3, 2025, revealed that the facility concluded that, Nurse [Employee E17, licensed nurse] failed to provide requested pain medication to resident with 8/10 reported pain. Nurse failed to report resident pain and lack of medication to oncoming shift or physician. Nurse failed to properly document on MAR administration of pain medication at the time the pill was lost. This nurse has been found to be neglectful of appropriately managing the resident's pain.</p> <p>Interview on April 2, 2025, at 11:55 a.m. the Nursing Home Administrator revealed that Employee E17, licensed nurse, was terminated from employment at the facility for withholding Resident R16's pain medication and that the facility determined that the outcome of the investigation was substantiated neglect.</p> <p>Review of Report Form for Investigation of Alleged Abuse, Neglect, Misappropriation of Property revealed that the nature of abuse investigated by the facility was verbal abuse.</p> <p>Review of Description of Incident revealed the following: On January 5, 2025, at 6:45 PM, Resident R57 reported that the previous evening, January 4, 2025, Nurse's Aide, Employee E20 was complaining about having to change Resident R57 again. Resident R57 then pointed his finger at Employee E20 and stated to Employee E20 that He doesn't want to be here but wants to get better and to be able to walk again. Employee E20 then grabbed Resident R57's finger tightly for several seconds.</p> <p>Review of Findings of Facility Investigations revealed that the allegation was substantiated.</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>Employee E20 was no longer employed at the facility and was not available for interview.</p> <p>The Director of Nursing who investigated the incident was no longer employed at the facility and was not available to interview</p> <p>28 Pa Code 201.18(b)(1) Management</p> <p>28 Pa Code 201.29(a)(c) Resident rights</p> <p>28 Pa Code 211.10(c) Resident care policies</p> <p>28 Pa Code 211.12(c) Nursing services</p> <p>28 Pa Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39344</p> <p>Based on clinical record reviews and interviews with staff, it was determined that the facility failed to accurately complete an MDS assessment for one of three closed records reviewed (Resident R55).</p> <p>Findings include:</p> <p>Clinical record review for Resident R55 revealed a Discharge Note, dated January 5, 2025, at 2:10 p.m. which indicated that the resident discharged home with family.</p> <p>Review of Resident R55's Discharge MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated January 5, 2025, revealed that the resident was discharged on [DATE], to a short-term general hospital.</p> <p>Interview on April 3, 2025, at 11:58 a.m. Employee E11, nurse assessment coordinator, confirmed that Resident R55 discharged home and that the discharge MDS assessment was not completed accurately.</p> <p>28 Pa Code 211.5(i) Medical records</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38947</p> <p>Based on review of facility policy, facility documents, clinical records, and interview with staff, it was determined the facility failed to develop a comprehensive care plan and interventions related to pain management, foot care and compression stocking for two of 17 resident clinical record reviewed (Resident R42 and Resident R47).</p> <p>Findings include:</p> <p>A review of the undated facility policy titled, Individualized Care Plan, revealed, the IDT develops comprehensive care plan addressing the residents most acute problems. The comprehensive care plan will include services that are to be furnished to attain or maintain the residents highest practicable physical, mental and psychological well-being.</p> <p>Review of Resident R43 revealed that Resident R43 was admitted to the facility on [DATE], with diagnoses of Central Cord Syndrome at C4 level, Spinal stenosis Lumbar Region, displaced fracture of acromial process, left shoulder.</p> <p>Observation of Resident R43 conducted on April 1, 2025, at 9:04 a.m., revealed that Resident R43 was in bed awake with left arm in a sling. Interview with Resident R43 conducted during the observation revealed that he had a left shoulder fracture. Further Resident R43 revealed that he takes pain medications for pain on his shoulder.</p> <p>Review of Resident R43's physician's ordered revealed an order for Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen), Give 2 tablet by mouth every 12 hours for 1000 milligrams (mg) Max 3G/day-order date of March 14, 2025.</p> <p>Review of Resident R43's current care plan revealed that there was no care plan develop for pain management.</p> <p>Review of the resident's Inpatient Discharge Summary dated 2/6/2025 indicated that the resident was admitted to the hospital on January 30, 2025 after having a fall at home. The resident was transferred to the facility on [DATE] for rehabilitation services.</p> <p>Review of the April 2025 physician orders for Resident R47 included the following diagnosis: diabetes (a condition characterized by elevated levels of blood glucose ,and a condition that makes an individual with the diagnosis at greater risks for developing foot problems ); hypertension (high blood pressure); hyperlipidemia (high cholesterol.) and sleep apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts), and morbid obesity. Continued review of the physician orders indicated that the resident was also being administered medication for the treatment of edema (swelling caused due to excess fluid accumulation in the body tissues, often the feet, legs and ankles).</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Resident R47 on April 2, 2024 at 11:30 a.m., Resident R47 reported that she had been at the facility since February 2025, had diabetes, had requested on a number of occasions to see the podiatrist, but stated that the facility had not followed up on her request to see the podiatrist.</p> <p>Review of the resident's physician orders included a physician's order dated February 12, 2025 for the resident to have a consultation with the podiatrist for missing toenails on the resident's 2nd and 3rd right toes, Podiatry consult for missing toenails on 2nd and 3rd Rt (right) toes.</p> <p>Review of the April 2025 physician orders also included a physician's order dated February 14, 2025 for the resident to see podiatry for neuropathy (a condition that often causes weakness, numbness and pain in the hands and feet) for bilateral lower extremities, Podiatry consult for neuropathy BLE (bilateral legs).</p> <p>Continued review of the resident's April 2025 physician orders included a third physician's order dated March 20, 2025 for the resident to have a podiatry consult to have her toe nails clipped, Podiatry consult for nail clipping.</p> <p>Continued review of the resident's clinical record did not show evidence that the resident was seen by the podiatrist, as ordered, to ensure that such care is provided to Resident R47 to avoid podiatric complications that Resident R47 ma be prone to due to her diabetes diagnosis .</p> <p>During an observation of the resident's feet on April 3, 2025 at 1:45 p.m. the resident's toe nails were observed as long, hard and yellowish.</p> <p>Review of the resident's person-centered plan of care did not include a plan of care related for the resident's foot care to ensure appropriate care and services are provided to the resident with a diagnosis of diabetes.</p> <p>During an interview with Employee E22 (licensed nurse) on April 3, 2025 at 11:47 a.m.it was confirmed that there was no person-centered plan of care for foot care for Resident R47.</p> <p>Review of the resident's April 2025 physician orders included a physician's order in March 2025 for the resident to wear compression stockings throughout the day (compression stockings- also known as compression socks, are specially made socks that fit tighter than normal so they gently squeeze an individual's legs. Compression stockings help improve an individual's blood flow and reduces pain and swelling in an individual's legs. They can also lower an individual's chances of getting deep vein thrombosis (DVT), a kind of blood clot, and other circulation problems).</p> <p>A physician's order dated March 3, 2025 indicated that the resident was to have compression stockings put on her legs in the morning. Compression stockings on in the am in the morning.</p> <p>Continued review of the April 2025 physician orders included a physician's order dated March 3, 2025 for the resident to take the compression stockings off at night. Compression stockings off at night at bedtime.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Employee E22 (licensed nurse) on April 3, 2025, at 11:47 a.m. the licensed nurse reported that she was the regularly assigned nurse for the resident and reported that the resident has reported that the compression socks were too tight. When asked if she ever notified that physician regarding the resident's concern that her compression stockings were too tight, the licensed nurse confirmed that she could provide no evidence that she notified that physician to assess the resident's complaint that the compression stockings were too tight for her to wear, as ordered.</p> <p>Review of the March 2025 Treatment Administration Record (TAR) revealed that the compression socks were not applied to that resident from March 3, 2025 through March 30, 2025. On March 3, 2025, the code UT, which means Unable to Tolerate, was coded for that date. March 4, 2025-March 30, 2025, were all blank, indicating that they were not applied.</p> <p>During an interview with Employee E22 (licensed nurse) on April 3, 2025 at 11:47 a.m it was confirmed that there was no person-centered plan of care for compression stockings for Resident R47.</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa Code 211.10(d) Resident care policies</p> <p>28 Pa. Code 211.12 (c)(d)(1) Nursing Services</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38947</p> <p>Based on observations, staff interviews and the review of clinical records, it was determined that the facility failed to follow a physician's order related to the application of compression stockings, and failed to clarify/notify the physician of the expected time of the completion of an ultrasound study for 2 out of 17 residents reviewed (Resident R47 and Resident R35).</p> <p>Findings include:</p> <p>Review of the resident's Inpatient Discharge Summary dated 2/6/2025 indicated that the Resident R47 was admitted to the hospital on January 30, 2025 after having a fall at home. The resident was transferred to the facility on [DATE] for rehabilitation services.</p> <p>Review of the April 2025 physician orders for Resident R47 included the following diagnoses diabetes (a condition characterized by elevated levels of blood glucose ,and a condition that makes an individual with the diagnosis at greater risks for developing foot problems); hypertension (high blood pressure); hyperlipidemia (high cholesterol.) and sleep apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts, and morbid obesity. Continued review of the physician orders indicated that the resident was also being administered medication for the treatment of edema (swelling caused due to excess fluid accumulation in the body tissues, often the feet, legs and ankles).</p> <p>During an interview with Resident R47 on April 2, 2024 at 11:30 a.m., Resident R47 reported that she had been waiting for compression stockings that fit. Resident R47 was observed with no compression stockings on during group. She then stated, The ones (compression stockings) they give me are very small. Do you see how big my ankles and legs are? I need to wear them, but they want me to wear compression stockings for someone who's ankles and legs are her size (pointed to another resident whose ankles and legs were smaller than Resident R47's).</p> <p>Review of the resident's April 2025 physician orders included a physician's order for the resident to wear compression stockings throughout the day (compression stockings- also known as compression socks, are specially made socks that fit tighter than normal so they gently squeeze an individual's legs to help improve an individual's blood flow, educe pain and swelling in an individual's legs and lower an individual's chances of getting DVT, a kind of blood clot, and other circulation problems).</p> <p>A physician's order dated March 3, 2025 indicated the use of compression stockings to be on in the morning.</p> <p>Continued review of the April 2025 physician orders included a physician's order dated March 3, 2025 for the resident to take the compression stockings off at night. Compression stockings off at night at bedtime.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Employee E22 (licensed nurse) on April 3, 2025, at 11:47 a.m. the licensed nurse reported that she was the regularly assigned nurse for the resident and reported that the resident has reported to her that the compression stockings were too tight and that the resident did not want to wear them. When asked if she ever notified that physician regarding the resident's concern that her compression stockings were too tight, the licensed nurse confirmed that she could provide no evidence that she notified that physician to assess the resident's complaint that the compression stockings were too tight for her to wear, as ordered.</p> <p>Review of the March 2025 Treatment Administration Record (TAR) revealed that the compression stockings were not applied to the resident from March 3, 2025 through March 30, 2025. On March 3, 2025, the code UT, which means Unable to Tolerate, was coded by nursing staff for that date. March 4, 2025-March 30, 2025, were all blank, indicating that they were not applied.</p> <p>Review of March 2025 physician orders for Resident R47 included a physician order dated February 28, 2025 for a venous Doppler (a test used to identify any blockages or clots that may be signs of diseases such as deep vein thrombosis (DVT-a blood clot usually in the leg).</p> <p>Review of physician notes dated February 28, 2025 at 9:28 a.m. documented that Resident R47 reported that she was experiencing left leg pain at the calf . The physician prescribed Tylenol to the resident for her pain.</p> <p>Review of the Doppler Report for Resident R47 revealed that the doppler study was not completed until March 2, 2025 inspite of the resident experiencing pain on the calf area.</p> <p>Continued review of the clinical record did not show evidence that the facility clarified with the physician if the doppler test should be completed sooner for Resident R47 due to calf pain.</p> <p>Review of March 2025 physician orders for Resident R35 include the following diagnoses diabetes; hypertension (high blood pressure) and repeated falls and colon cancer.</p> <p>Continued review of physician orders included a physician's order dated March 14, 2025 for the resident to have a [NAME] Doppler completed to her bilateral lower extremities to rule out the resident having a DVT.</p> <p>Review of a physician's note dated March 14, 2025 at 12:51 p.m. revealed that during the physician's examination the physician assessed the resident's bilateral lower extremities as having edema, increased warmth, with erythema (redness of the skin) . The physician indicated in the notes that a bilateral venous doppler to rule out a DVT would be ordered.</p> <p>Review of a nursing note dated March 17, 2025 at 12:38 p.m. indicated that the resident complained of pain in her bilateral lower extremities, and when assessed by nursing the resident bilateral lower extremities were warm to touch.</p> <p>Review of a physician's note dated March 18, 2025 at 4:38 p.m. indicated that the [NAME] doppler was ordered on March 14, 2025 but will note be done until March 18, 2025. The physician documented in the progress note that during the assessment of the resident, the resident reported some pain down her right leg.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Doppler Report for Resident R35 and dated March 18, 2025 indicated that the test was completed on March 18, 2025.</p> <p>Continued review of the clinical record did not show evidence that the facility clarified with the physician if the doppler test should be completed sooner for Resident R35 due to the health implications associated with a DVT.</p> <p>During an interview with the Regional Nurse, Employee E5 on April 3, 2025 at 12:08 p.m. it was discussed that review of the clinical records for Resident R35 and R47 did not show evidence of other precautions that were to be put in place for possible dvt for both residents and that the physician was contacted related to time frame of the completion of the doppler studies.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38947</p> <p>Based on observations, interviews and the review of clinical records, it was determined that the facility failed to ensure that podiatrist services were provided for 1 out of 17 residents reviewed (Resident R47).</p> <p>Findings include:</p> <p>Review of the resident's Inpatient Discharge Summary dated 2/6/2025, indicated that the resident was admitted to the hospital on January 30, 2025 after having a fall at home. The resident was transferred to the facility on [DATE] for rehabilitation services.</p> <p>Review of the April 2025 physician orders for Resident R47 included the following diagnoses of diabetes (a condition characterized by elevated levels of blood glucose ,and a condition that makes an individual with the diagnosis at greater risks for developing foot problems ); hypertension (high blood pressure); hyperlipidemia (high cholesterol).</p> <p>During an interview with Resident R47 on April 2, 2024 at 11:30 a.m., Resident R47 reported that she had been at the facility since February 2025, had diabetes, had requested on a number of occasions to see the podiatrist, but stated that the facility had not followed up on her request to see the podiatrist.</p> <p>Review of the resident's physician orders included a physician's order dated February 12, 2025 for the resident to have a consultation with the podiatrist for missing toenails on the residents 2nd and 3rd right toes, Podiatry consult for missing toenails on 2nd and 3rd Rt (right) toes.</p> <p>Review of the April 2025 physician orders also included a physician's order dated February 14, 2025 for the resident to see podiatry for neuropathy (a condition that often causes weakness, numbness and pain in the hands and feet) for bilateral lower extremities, Podiatry consult for neuropathy BLE (bilateral legs).</p> <p>Continued review of the resident's April 2025 physician orders included a third physician's dated March 20, 2025 for the resident to have a podiatry consult to have her toe nails clipped, Podiatry consult for nail clipping.</p> <p>Continued review of the resident's clinical record did not show evidence that the resident was seen by the podiatrist.</p> <p>During an observation of the resident's feet on April 3, 2025 at 1:45 p.m. the resident's toe nails were observed as long, hard and yellowish.</p> <p>During a discussion with Employee E5 (Regional Nurse) on April 3, 2025 at 12:08 p.m. the Regional Nurse, Employee E5 confirmed that the resident had not been seen by the podiatrist, as ordered by the physician.</p> <p>28 Pa Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46508</p> <p>Based on clinical record review and interviews with staff, it was determined that the facility failed to obtain orders for urinary catheter for one of two clinical records of residents with urinary catheters reviewed (Resident R46).</p> <p>Findings include:</p> <p>Review of Resident R46's clinical record revealed that resident was admitted to the facility on [DATE], with diagnoses of but not limited to Chronic Urinary Tract Infection, Chronic Tubulo-interstitial Nephritis, Benign Prostatic Hypertrophy with Lower Urinary Tract Symptoms, Bladder Neck Obstructions and Uro-genital Implant</p> <p>Further review of Resident R46's clinical record revealed that Resident R46 was discharged to the hospital on March 25, 2025, and was readmitted to the facility on [DATE].</p> <p>Review of Resident R46's clinical record (service evaluation and health assessment) dated March 29, 2025, revealed that resident R46 was admitted s/p (status post) pyelonephritis recurrent UTI (urinary track infection), has foley- (indwelling urinary catheter) intact and patent.</p> <p>Further review of Resident R46's physician orders revealed an order for: Chronic indwelling Foley catheter - 18F replaced in hospital 3/5/25-ordered 3.21.25 and was discontinued on 3.25.25-</p> <p>Further Review of Resident R46's clinical record revealed no order for an indwelling foley catheter when the resident was readmitted to the facility on [DATE].</p> <p>Observation of Resident R46 conducted on March 31, 2025, at 10:24 a.m. during the tour of the first-floor unit revealed that Resident R46 was in bed asleep.</p> <p>Further observation revealed that Resident R46 had a clear tubing connected to a urine bag located under Resident R46's bed.</p> <p>Interview with Senior DNS (Director of Nursing Services) Employee E4 conducted on April 2, 2025, at 1:55 p. m. confirmed that Resident R46 has a foley catheter and that there was no order for catheter for Resident R46 upon his return from the hospital on March 29, 2025.</p> <p>28 Pa Code 211.12(d)(1) Nursing services</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39344</p> <p>Based on observations, review of facility policies, clinical record reviews and interviews with residents and staff, it was determined that the facility failed to ensure that intravenous (IV) devices were maintained in accordance with professional standards of practice for one of one residents reviewed for intravenous therapy (Resident R106).</p> <p>Findings include:</p> <p>Review of facility policy, Vascular Access Devices and Infusion Therapy Procedure, Peripherally Inserted Central Line Catheter (PICC)[ a thin soft tube inserted in a vein in the arm with the tip of the tube positioned in a large vein that carries blood to the heart] dated October 2024, revealed, Measure circumference of upper arm before insertion or on admission as a baseline and when clinically indicated to assess for the presence of edema [excess fluid] and possible deep vein thrombosis [blood clot]. Measure 10 c.m. [centimeters] above the insertion site. Measure external length of PICC catheter at insertion or on admission, with each dressing change, and when clinically indicated if catheter dislodgement is suspected.</p> <p>Review of Resident R106's care plan revealed that the resident was admitted to the facility on [DATE], to receive intravenous antibiotic therapy due to sepsis (infection in the blood).</p> <p>Review of Resident R106's physician orders revealed an order, dated March 25, 2025, to change the IV dressing, caps, measure the external catheter length and arm circumference every week, starting with the day the resident arrived at the facility and continuing every Tuesday. Continued review revealed an order, dated March 25, 2025, to administer cefazolin (antibiotic medication) intravenously every 12 hours for bloodstream infection.</p> <p>Continued review of Resident R106's clinical record, including March and April 2025 Medication and Treatment records, as well as progress notes, revealed no indication that the dressing on the PICC was changed or that the catheter length or arm circumference were measured at any time since the resident was admitted to the facility.</p> <p>Observation on March 31, 2025, at 12:42 p.m. revealed that Resident R106 had a PICC line in his right upper arm; the dressing on the PICC was dated March 24, 2025. Resident R106 stated that he received antibiotic medication through the PICC line twice per day.</p> <p>Observation on April 2, 2025, at 2:30 p.m. revealed that Resident R106's PICC line dressing was still dated March 24, 2025. Resident R106 stated that the dressing had not been changed at any time since his admission to the facility.</p> <p>Observation and interview on April 2, 2025, at 2:46 p.m. the Director of Nursing confirmed that the dressing on Resident R106's PICC line was dated March 24, 2025, and that it was overdue to be changed.</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46508</p> <p>Based on clinical record review and interviews with staff, it was determined that the facility failed to obtain orders for oxygen for one of 17 clinical records reviewed (Resident R21).</p> <p>Findings include:</p> <p>Review of Resident R21's clinical record revealed that Resident R21 was admitted to the facility on [DATE], with diagnoses of Chronic Respiratory failure with Hypoxia (low levels of oxygen).</p> <p>Further review of Resident R21's clinical record revealed a care plan for oxygen therapy related to chronic heart failure date initiated: 03/11/2025.</p> <p>Further review of Resident R21's clinical record revealed that there was no physician's orders for oxygen.</p> <p>Review of Resident R21's Daily Skilled Evaluation dated March 26, 2025 revealed that under section Skilled Services, 7a, #1:Oxygen was coded yes and 7c. Respiratory management: document evaluation and response to above selected services (may include respiratory pattern changes, lung sounds, O2 sat monitoring, endurance levels, shortness of breath upon exertion, shortness of breath lying flat, shortness of breath at rest, oxygen rate/route, tracheostomy care/status, notable change in respiratory status)had the following notation: The resident is on continuous O2-2L via nasal cannula, no s/s (signs/ of respiratory distress. Breo, 1 PUFF BY MOUTH DAILY FOR ASTHMA.</p> <p>Observation on Resident R21 conducted on March 31, 2025, at 10:55 a.m. during the tour of the first-floor unit revealed that Resident R21 was in bed, awake.</p> <p>Further observation revealed that Resident R21 was on an oxygen concentrator via nasal canula at 2 liters/minute.</p> <p>Interview with Resident R21 revealed that the resident used oxygen and stated having been on oxygen for a while.</p> <p>Interview with licensed nurse Employee E21 confirmed that Resident R21 was on oxygen at 2 liters/minute. Further, Employee E21 also revealed that the oxygen tubing is changed every Sunday during the 3-11 shift.</p> <p>Interview with Senior DNS (Director of Nursing Services) Employee E4 conducted on April 2, 2025, at 1:57 p. m. confirmed that there was no order for oxygen for Resident R21.</p> <p>28 Pa Code 211.12(d)(1) Nursing services</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39344</p> <p>Based on observations, review of clinical records, facility documentation, and interviews with residents and staff, it was determined that the facility failed to ensure that nursing staff possessed the appropriate competencies and skill sets related to the care of residents with intravenous (IV) devices for two of five employees reviewed for IV skills competencies (Employees E15 and E16).</p> <p>Findings include:</p> <p>Observation on March 31, 2025, at 12:42 p.m. revealed that Resident R106 had a PICC (intravenous) line in his right upper arm. Resident R106 stated that he received antibiotic medication through the PICC line twice per day.</p> <p>Review of Resident R106's care plan revealed that the resident was admitted to the facility on [DATE], to receive intravenous antibiotic therapy due to sepsis (infection in the blood).</p> <p>Review of Resident R106's physician orders revealed an order, dated March 25, 2025, to administer cefazolin (antibiotic medication) intravenously every 12 hours for bloodstream infection. Continued review revealed an order, dated March 25, 2025, to flush the resident's IV line with 10 m.l. (milliliters) of normal saline every shift for IV patency.</p> <p>Review of Resident R106's Medication Administration Records for March 2025, revealed that Employees E15 and E16, licensed nurses, administered Cefazolin and flushed the resident's PICC line.</p> <p>Review of facility documentation related to IV skills evaluations revealed that there was no documentation available for review at the time of the survey to indicate that Employees E15 and E16, licensed nurses, were evaluated to ensure competency of IV administration.</p> <p>Interview on April 2, 2025, at 12:29 p.m. Employee E4, regional nurse, confirmed that the facility was not able to provide evidence that Employees E15 and E16, licensed nurses, were evaluated to ensure competency of IV administration.</p> <p>28 Pa Code 201.19(7) Personnel policies and procedures</p> <p>28 Pa Code 211.12(d)(1) Nursing services</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>39344</p> <p>Based on observations, review of facility policies and interviews with staff, it was determined that the facility failed to ensure that drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled for two of three medication carts reviewed (Second floor nursing unit A and C medication carts).</p> <p>Findings include:</p> <p>Review of facility policy, Narcotic Reconciliation dated revised July 11, 2022, revealed, Controlled medications are counted at the beginning and end of each shift by two authorized team members at the same time. The incoming authorized team member counts the controlled medication. The outgoing authorized team member visually verifies the actual number of controlled medications regardless of form against the amounts listed on the declining inventory sheets. The number of unit-dose/blister pack medication cards is also verified during the drug count process. This process is done together for each controlled medication to be reconciled.</p> <p>Observation on April 1, 2025, at 9:08 a.m. of the second floor nursing unit A medication cart narcotic log, with Employee E13, licensed nurse, revealed that the number of blister pack medication cards was not documented during the shift-to-shift narcotic medication reconciliation process. Interview, at the time of the observation, Employee E13, licensed nurse, confirmed the above finding and stated that a total count of the medication cards should have been documented.</p> <p>Observation on April 1, 2025, at 9:37 a.m. of the second floor nursing unit C medication cart narcotic log, with Employee E12, licensed nurse, revealed that the number of blister pack medication cards was not documented during the shift-to-shift narcotic medication reconciliation process. Interview, at the time of the observation, Employee E12, licensed nurse, confirmed the above finding.</p> <p>Interview on April 1, 2025, at 10:47 a.m. the Director of Nursing confirmed that card counts were not completed during the shift-to-shift narcotic medication reconciliation process for the second floor nursing unit A and C medication carts and confirmed that this failure increased the risk for diversion of narcotic medications.</p> <p>28 Pa Code 211.12(d)(1) Nursing services</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38947</p> <p>Based on observations, review of facility policy and staff interviews, it was determined that the facility failed to ensure that food was stored, prepared, distributed and served food in accordance with professional standards for food service safety.</p> <p>Findings include:</p> <p>Review of the facilities, Food Storage, Preparation and Service policy with a revision date of April 11, 2022 indicated that food storage areas included walk in and reach in refrigerators and freezers, under the counter refrigeration and freezer units, bistro and common area refrigerator and freezer units, and any dry storage area units. The policy also state that all food items are labeled, dated and rotated to maintain a system of First In First Out. Continued review of the policy indicated that all refrigeration, freezer and dry storage areas are outfitted with a properly calibrated thermometer.</p> <p>Observation of the 3rd floor kitchen on April 2, 2025 at 11:00 a.m. with the Director of Culinary Services (Employee 23), the Director of Maintenance (Employee E24) and the Nursing Home Administrator revealed the following:</p> <p>There were two ice cream freezer units with various flavors of ice cream them with no thermometer present in them. The temperature of the ice cream in the units could not be determined.</p> <p>The walk in freezer contained an ice cream container that had a brown paper-like lid that was torn, undated and not properly covering the ice cream resulting the ice cream being partially exposed. The container did not contain a date that it was opened by dietary staff, and did not contain a documented expiration date identified by dietary staff.</p> <p>A coffee flavored ice cream container in the walk in freezer had an opening date of March 18th written in by facility staff, but year documented on it, and no expiration date documented and identified on it by dietary staff.</p> <p>A [NAME] flavored ice cream container in the walk in freezer had an opening date as what appeared to be March 27th or March 29th, but no year documented on it and no expiration documented or identified on it by dietary staff.</p> <p>A butter pecan reduced fat ice cream in the walk in freezer has a brown paper like lid that was saturate with a wet red-like colored substance. The lid was just lying on top of the ice cream container and did not properly fit it, and appeared to be too big to fit the ice cream container. Although the ice had been open and used, there was no date documented by facility staff on the container indicating when it was opened, and no expiration date documented and identified by dietary staff.</p> <p>A box of crab legs were observed in the walk in freezer had been open, but there was no date documented by dietary staff on the container indicating when it was opened, and no expiration date documented ad identified by dietary staff.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A box of croissants were observed in the walk in freezer were open, but there was no date documented by dietary staff on the container indicating when it was opened, and no expiration date documented and identified by dietary staff.</p> <p>A box of apple pastries were observed in the walk in freezer were open, but there was no date documented by dietary staff on the container indicating when it was opened, and no expiration date documented and identified by dietary.</p> <p>28 PA Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(3) Management</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>38947</p> <p>Based on observations, it was determined that the facility failed to properly dispose of garbage and refuse.</p> <p>Findings Include:</p> <p>Observations on April 2, 2026 with the Culinary Director (Employee E23), the Director of Maintenance (Employee E24), and the Nursing Home Administrator on April 2, 2025 at 11:35 a.m. near the trash compactors (areas on the sides of , front of, back of, and underneath of the trash compactors) located near the loading dock receiving area revealed the following:</p> <p>Various trash items such as tops to jars, cans, sugar packets bottles and cardboard boxes were seen in the above referenced areas. The presence of fall leaves and 1 dinner plate was even also among the trash/debris. Various other trash items had been present for so long that they turned black, appeared moist, and the type of trash/debris it once was could not be determined due to its diminished appearance.</p> <p>A Styrofoam food container whose food compartments were filled with dark stagnant water, in addition to other trash/debris. A paper scattered around the trash compactors, in addition to plastic gloves, a white face or bath towel, and a cigarette butt. A clear plastic bag was observed in the back of one of the trash compactors filled with stagnant, black water. A strong stench was also present in the area of the trash compactors, in addition to grime (soot, smut, or dirt adhering to or embedded in a surface) present on the ground areas on the sides of, front of, back of, and underneath of the trash compactors.</p> <p>All of the above-referenced parties were present for the above referenced tour and observations regarding trash and debris in the in front of, on the side of, and in back of the trash compactors.</p> <p>28 Pa. Code 201.18(b)(3) Management</p> <p>28 Pa. Code 207.2(a) Administrator's responsibility</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46508</p> <p>Based on observation, review of facility policy and procedure, staff interview and review of clinical record, it was determined that the facility failed to maintain an effective infection control program related to contact precaution and maintenance of urinary catheter/urine bag for two of 17 residents observed. (Resident R46 and Resident R159)</p> <p>Findings include:</p> <p>Review of facility policy on Transmission Based Precaution revealed that transmission-based precautions are used for residents with documented or suspected infection or colonization with highly transmissible pathogens. Communicate the type of precautions required through verbal reports, hand-off reports, entering on the alert page in [Electronic System] and posting signs outside the resident's rooms. Contact Precautions for resident with known or suspected infections that are of an increased risk of being transmitted by direct contact with the resident or the resident's environment. Use the following guidelines to manage the care of residents on contact precautions. PPE (personal protective equipment)-use gloves and gowns when in contact with resident or the resident's environment. Putting on PPE prior to entering the resident's room and removing PPE prior to leaving the resident's room helps contain pathogens.</p> <p>Review of Resident R46's clinical record revealed that resident was admitted to the facility on [DATE], with diagnoses of Chronic Urinary Tract Infection, Chronic Tubulo-interstitial Nephritis, Benign Prostatic Hypertrophy with Lower Unitary Tract Symptoms, Bladder Neck Obstructions and Uro-genital Implant.</p> <p>Further review of Resident R46's clinical record revealed that Resident R46 was discharged to the hospital on March 25, 2025, and was readmitted to the facility on [DATE].</p> <p>Review of Resident R46's clinical record (service evaluation and health assessment) dated March 29, 2025, revealed that Resident R46 was admitted s/p (staus post) pyelonephritis (kidney infection) recurrent UTI (urinary track infection), has foley (indwelling catheter).</p> <p>Further review of Resident R46's physician orders revealed an order for: Chronic indwelling Foley catheter - 18F replaced in hospital 3/5/25-ordered 3.21.25 and was discontinued on 3.25.25.</p> <p>Observation of Resident R46 conducted on March 31, 2025, at 10:24 a.m. revealed that Resident R46 had a clear tubing connected to a urine bag located under Resident R46's bed. The urine bag was lying on the floor on the right side of Resident R46's bed. Further, an amber colored liquid was observed in the tubing and in the urine bag.</p> <p>Interview with licensed nurse Employee E21 conducted at the time of the observation confirmed that Resident R46's urine bag was lying flat on the floor.</p> <p>Review of Resident R159's clinical record revealed that Resident R159 was admitted to the facility on [DATE], with diagnoses of but not limited to Malignant Ascites.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395801	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/03/2025
NAME OF PROVIDER OR SUPPLIER  Quadrangle		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of Resident R159'd clinical record revealed a physician's order for contact isolation precautions for C. Diff (Clostridium Difficile- a bacterium that causes infection of the colon causing diarrhea and inflammation of the colon) with order date of March 28, 2025.</p> <p>Observation conducted on March 31, 2025, at 10:52 a.m. revealed that Resident R159's bedroom door had a signage with instructions to see nurse prior to entering.</p> <p>Interview with licensed Employee E21 conducted at the time of the observation revealed that Resident R159 was on contact precaution.</p> <p>Further observation revealed that Social Worker Employee E7 was observed inside Resident R159's room without PPE (personal protective equipment). Employee E7 then came out of the room.</p> <p>Interview with Employee E7 conducted at the time of the observation and after Employee E7 came out of Resident R159's room revealed that she only had to wear PPE when providing care and that she wasn't providing care at the time. Employee E7 then proceeded to ask Employee E21 the type of precaution Resident R159 was on. Employee E21 proceeded to review Resident R159's clinical record after which Employee E21 confirmed that Resident R21 was on contact precaution due to C. Diff.</p> <p>28 Pa Code 211.12 (d)(1)(5) Nursing services</p>		