STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395819	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring Heart Rehabilitation and Nursing Center	6445 Germantown Avenue Philadelphia, PA 19119

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on clinical record review, interviews with staff and reviews of policies and procedures, it was determined that the facility failed to ensure that medication administration records were completed for two of seven residents. (Residents Cl1 and Cl2). Findings include:A review of the policy titled medication administration dated November 28, 2016, revealed that it was the responsibility of the licensed nursing staff to administer medications in accordance with professional standards of practice and as ordered by the physician. The policy also indicated that the medication was to be administered as ordered by the physician and in accordance with manufacturers' specifications. The nurse was to observe the resident consume the medication. The medication was to be recorded onto the medication administration record, which was part of the resident's clinical record. A review of the policy titled medical record documentation dated November 2025, revealed that each resident's medical record was to contain an accurate representation of the resident through complete, accurate and timely documentation. The policy indicated that licensed staff and the interdisciplinary team members were to document all assessments, observations and services provided for each resident in the medical record in accordance with state law and the facility policy. The policy said that documentation shall be factual, accurate, relevant and complete containing sufficient details about the resident's care and/or responses to care. Clinical record review for Residents Cl1 and Cl2 revealed that the nursing staff failed to completely and accurately document that medications and treatments were administered as ordered by the physician.Clinical record review for Resident Cl1 revealed that this resident had diagnoses of asthma, hypertension, depression, hypoxia, diabetes mellitus and severe stenosis with myelomalacia. The physician had ordered formoterol fumarate inhalation nebulizer solution 20MCG/2ml inhale orally via nebulizer two times a day for asthma. The licensed nurse documented on November 2, 2025, that the 5:00 p.m., dose of inhalation medication for asthma was not administered to Resident Cl1. A licensed nurse documented on November 4 and November 9, 2025, that the 5:00 p.m., doses of medication for formoterol fumarate inhalation nebulizer solution 20MCG/2ml inhale orally via nebulizer were not administered to Resident Cl1. The physician had ordered pregabalin oral capsule 25 mg be administered twice a day for cerebral vascular accident for Resident Cl1. A licensed nurse documented that on November 4, 9 and 10, 2025 the 5:00 p.m., doses of pregabalin oral capsule 25 mg were not administered to Resident CL1 for the diagnosis of cerebral vascular accident. A licensed nurse documented that on December 10, 2025, and December 11, 2025, the 9:00 a.m., the doses of pregabalin oral capsule 25 mg were omitted for Resident Cl1 for the treatment and diagnosis of cerebral vascular accident. The physician had ordered insulin lispro injection three times a day for a diagnosis of diabetes mellitus with a sliding scale amount of insulin, after a blood glucose reading was taken and recorded by the nurse for Resident Cl1. A licensed nurse documented at 5:00 p.m., on November 4 and 9, 2025 that blood glucose was not taken or recorded for Resident Cl1 and that insulin for diabetes mellitus was not administered as ordered by (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the physician for Resident Cl1. The physician ordered topical gel 1% to be applied for bilateral knee pain for Resident Cl1. On November 4 and November 9, 2025, the 5:00 p.m., doses of topical cream were not applied to the bilateral knees for pain for Resident Cl1 as ordered by the physician. Clinical record review for Resident Cl2 revealed that this resident had diagnoses of anxiety disorder, end stage renal disease, sepsis and spina bifida. Clinical record review for Resident Cl2 revealed that the physician had ordered Ativan (an antianxiety agent) orally 2mg 1 tablet by mouth every 12 hours for anxiety. The licensed nurse documented on December 11, 2025, that the medication Ativan was administered to Resident Cl2 at 9:00 a.m., and 9:30 p.m., as ordered by the physician. A licensed nursing staff member documented that at 9:30 p.m., on December 12, 2025, the 2mg dose of Ativan was omitted for Resident Cl2. A licensed nurse documented that the 2mg dose of Ativan was not administered to Resident Cl2 at 9:00 a.m., on December 13, 2025, as ordered by the physician. A licensed nurse documented that on December 16, 2025, the 9:30 p.m., dose of 2mg of Ativan was not administered to Resident Cl2 as ordered by the physician. A licensed nurse documented on December 18, 2025, that the 2mg dose of Ativan was not administered to resident Cl2 as prescribed by the physician. Interview with the assistant director of nursing, Employee E2, at 10:00 a.m., on December 30, 2025, confirmed the lack of medical record documentation to indicate that Residents Cl1 and Cl2 received medications and treatments according to professional standards of nursing practice for medication administration and required medical record documentation. 28 PA. Code 211.10(a)(b)(c)(d) Resident care policies28 PA. Code 211.12(d)(1)(3)(5) Nursing services28 PA. Code 211.5(f)(i)(ii)(iii)(vii)(viii)(ix)(x) Medical records