

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395819	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Caring Heart Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>47975</p> <p>Based on observations, review of facility policy, and interview with staff, it was determined that the facility failed to ensure that residents were treated with dignity and respect related to the dining experience on one of four floors reviewed. (Third floor)</p> <p>Findings Include:</p> <p>Review of facility policy titled, The Person Centered Dining Approach undated states, Policy: Person centered care and hospitality services, including dining, will be a vital part of everyday living. The person centered dining approach will focus on each individual's needs related to food, nutrition, and dining. 8. Use of napkins will be encouraged, and dignified clothing protectors will be available as needed or requested. 11. Staff will sit next to a person when assisting them with eating (rather than standing over them. 13. Individuals at the same table will be served and assisted at the same time.</p> <p>Observation of the dining experience was held on August 5, 2024 at 12:21 p.m. on the third floor Cliveden unit. The lunch menu posted listed fish sticks, garden rice, parsley carrots, fruit crisp, and milk. At 12:27 p.m. the food cart arrived at this time there were nineteen resident's seated at nine different tables in the dining room. Staff started to pass out the food trays and residents were not being served at the tables together. The staff were finished passing out the trays at 12:30 p.m. and at this time only nine out of the nineteen residents had been served their lunch trays. The remained of the food trays on the cart were for residents eating in their rooms. At 12:32 p.m. dietary staff left the dining room to serve residents in their rooms.</p> <p>Observation of dining service on August 5, 2024 at 12:35 p.m. revealed a Resident R49 appeared to have a vision impairment and asked Nurse Aide, Employee E15 to assist her with feeding. Review of Resident R49's ticket revealed her food was supposed to be served in bowls, but instead her food was served on Styrofoam plates. During the feeding Nurse Aide, Employee E15 stood next to Resident R49 while feeding her. The resident was observed with food on her shirt and was not wearing a clothing protector. Nurse Aide, Employee E15 at 12:37 p.m. revealed staff use towels to protect the resident's clothing if needed. Employee E15 stated that they have not had clothing protectors for several months.</p> <p>Observation of the dining service on August 5, 2024 revealed the second food cart tray arrived at 12:37 p.m. to the dining area. All residents in the dining area were served by 12:45 p.m.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>28 Pa Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.29(d) Resident Rights</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471</p> <p>Based on observation and staff and interviews iwth resident's representative, it was determined that the facility failed to provide a safe, clean, comfortable and homelike environment for residents on one of six nursing units and 2nd floor patio. (3rd Floor Cliveden and 2nd floor patio)</p> <p>Findings include:</p> <p>Interview with Resident R103's family member on August 5, 2024, at 11:01 a.m. stated facility was not always clean, family member stated there is always trash on the floor of the shower room and clutter in the shower room.</p> <p>Observation of the first shower room of 3rd floor on August 5, 2024, at 11:07 a.m. with third floor unit manager revealed there was brown colored dried stain dripping on the wall, unit manager stated there was shower room at the same location on the top floor. The corner had a broken tiles which exposed the dry wall. The toilet seat had yellowish colored stain, the tissue box had dust on it, broken border, and the shower curtain had yellow stain. There was also broken/missing base board molding in the shower room.</p> <p>Observation of the second shower room of 3rd floor on August 7, 2024, at 11:13 a.m. with third floor unit manager revealed that there were resident shoes, geri chair, pillows, blankets, housekeeping broom, and a mechanical lift in the shower room.</p> <p>Observation of the room [ROOM NUMBER] on August 7, 2024, at 10:54 a.m. revealed that the wall base board molding was broken. The blanket had yellow colored stain.</p> <p>Observation of the 2nd floor patio smoking area revealed that there were numerous cigarette buds on the floor through out the patio area.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p>		

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<p>F 0585</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>47975</p> <p>Based on observations, facility policy review, and staff interview, it was determined that the facility failed to provide residents the ability to file grievances anonymously for eight out of eight nursing units. Clivden fifth floor, Mount Airy fifth floor, Clivden fourth floor, Mount Airy fourth floor, Clivden third floor, Mount Airy third floor, Clivden second floor, Mount Airy second floor.</p> <p>Findings Include:</p> <p>Review of the facility policy titled, Grievance Policy with a revision date on November 28, 2021 states, Our facility will assist residents, their representatives, family members or resident advocates in filing a concern form when concerns are expressed, which may not be able to be handled immediately by the facility staff, requires further investigation, or requires consultation with other facility staff, the attending physician or outside service providers.</p> <p>Further review of the facility policy states, Procedure: Any resident, his/her representative, family member or advocate may file a Grievance Form regarding treatment, facility services, medical care, behavior of other residents or staff members, theft of property, missing items, discrimination, etc. without fear of threat or reprisal in any form. All new residents will be informed of the information on how to file a grievance and information on the name, phone number and contact information (including mail and email) for the facility grievance officer. Grievances may be received in writing, orally or anonymously. The same process will be followed regardless of the method in which a grievance in conveyed or the setting of the grievance, i.e. resident or family group, care conference, etc. Upon request, the facility will provide a copy of the grievance policy to the resident or resident representative.</p> <p>A tour was taken of the facility on August 7, 2024 at 12:50 p.m. The tour revealed no grievances boxes were found on the following units: Clivden fifth floor, Mount Airy fifth floor, Clivden fourth floor, Mount Airy fourth floor, Clivden third floor, Mount Airy third floor, Clivden second floor, Mount Airy second floor. A tour of the first floor revealed no evidence of a grievance box to allow for anonymous grievances.</p> <p>Interview on August 7, 2024 at 1:10 p.m. with the Social Work Director Employee E14 confirmed that there is no lock box in the facility to provide for anonymous grievances currently in the facility. Employee E14 stated that currently residents turn the grievance in by giving them to nursing, giving them to her, or putting the form under the door of her office.</p> <p>28 Pa. Code 201.18(b)(2) Management</p> <p>28 Pa. Code 201.29(a)(i) Resident rights</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47975</p> <p>Based on review of facility policies, clinical record review, observations and staff interviews, it was determined the facility failed to identify beds against the wall as a possible restraint and failed to assess the functional status of individual residents to determine the use of the restraint for three of thirty-seven residents reviewed. (Residents R189, R25, and R218).</p> <p>Findings Include:</p> <p>Review of facility policy titled, Restraints with a revision date of December 2019 states, Policy: To foster the philosophy ., in compliance with Federal and State Regulations and in accordance with HIPPA Regulations, it is the policy of to provide residents with a restraint-free environment which promotes independence, safe freedom of movement, dignity and overall quality of life. Residents with functional deficits all receive appropriate therapeutic measures, including assistive devices. Procedure: 1. Initiation of restraint a. The resident will be assessed for the need of a restraint b. It will be discussed with the resident and/or designated representative use of the restraint including risk vs. benefit c. Documentation of consent from the resident and/or designated representative will be placed on the chart documenting the use of the restraint. d. The licensed nursing staff will obtain a physician order for restraint. Order must include device to be used; medical/clinical symptoms; release time and interventions to be performed. e. Unit manager/Designee will document need for restraint, goals and interventions on the care plan. Interventions must include measure to avoid decline in residents' functional status related to use of restraint. f. The IDT will review monthly all residents for whom a restraint is in use.</p> <p>Observation on August 5, 2024 at 10:01 a.m. revealed Resident R189 had her bed pushed against the wall and no bed rails on the bed.</p> <p>Review of Resident R189's clinical record revealed Resident R189 was admitted to the facility on [DATE] with diagnoses of: Essential Hypertension, Hyperlipidemia, Hyperthyroidism, Gastro-Esophageal Reflux Disease, Epilepsy, Chronic Kidney Disease, and Heart Failure.</p> <p>Review of Resident R189's Minimum Data Set (MDS) completed July 24, 2024 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 0 indicating severe cognitive impairment.</p> <p>Review of Resident R189's care plan revealed the resident did not have a care plan in place for preference of the bed being against the wall.</p> <p>Observation on August 5, 2024 at 10:40 a.m. revealed Resident R25 had his bed pushed against the wall and no bed rails on the bed.</p> <p>Review of Resident R25's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses of: Spinal Stenosis, Pulmonary Embolism, Down Syndrome, Dementia, Protein-Calorie Malnutrition, Muscle Weakness, Retention of Urine, Chronic Gout, Lack of Coordination, Anemia, Hypothyroidism, Obstructive Sleep Apnea, and Syncope and Collapse.</p> <p>(continued on next page)</p>

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R25's Minimum Data Set (MDS) completed on July 9, 2024 revealed a Brief Interview for Mental Status (BIMS) score of 2 indicating severe cognitive impairment.</p> <p>Review of Resident R25's care plan revealed the resident did not have a care plan in place for preference of the bed being against the wall.</p> <p>Observation on August 5, 2024 at 11:11 a.m. revealed Resident R218 and had no bed rails.</p> <p>Review of Resident R218's care plan revealed the resident did not have a care plan in place for preference of the bed being against the wall.</p> <p>The Director of Nursing Employee E2 confirmed on August 6, 2024 at 2:15 p.m. that resident's that have their beds against the wall is because of their preference and the resident's care plan should have the preference included prior to the bed being placed against the wall.</p> <p>Review of Resident R218's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses of: Protein Calorie Malnutrition, Muscle Weakness, Lack of Coordination, Dysphagia, Deaf Nonspeaking, Hyperlipidemia, Cerebral Infraction, Hemiplegia and Hemiparesis, Anemia, Hypertension, and Depression.</p> <p>Review of Resident R218's Minimum Data Set (MDS) completed on July 2, 2024 revealed a Brief Interview for Mental Status (BIMS) score of 3 indicating severe cognitive impairment.</p> <p>Further review of Resident R189, R25, and R218's clinical records revealed no bed rail assessments had been completed.</p> <p>Interview on August 8, 2024 at 10:56 a.m. with the Director of Nursing Employee E2 revealed the facility does not utilize bed rails.</p> <p>28 Pa. Code 211.8(e)(f) Use of Restraints.</p> <p>28 Pa. Code 211.10(d) Resident Care Policies.</p> <p>28 Pa. Code:211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471</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 develop a baseline care plan within 48 hours of a resident's admission that included the minimum information necessary to properly care for a resident, for one of one resident reviewed related to substance abuse disorder (Resident R529).</p> <p>Findings include:</p> <p>Review of Resident R529's hospital record dated August 2, 2024, revealed that the resident had a history of polysubstance disorder (3 bundles of fentanyl daily, up to one bundle at a time and Xanax). Resident was started on Suboxone for drug addiction. Resident had severe wound with etiology related to drug use.</p> <p>Review of progress note for Resident R529 dated August 2, 2024, revealed that the resident was admitted to the facility on [DATE], with diagnosis of septic shock, opioid drug use, and depression.</p> <p>Review of Medication Administration Record for Resident R529 for August 2024 revealed that the resident was receiving nicotine patch for smoking dependence and suboxone for opioid abuse disorder. Resident also had an order for Naloxone for opioid abuse.</p> <p>Interview with Resident R529 on August 6, 2024, at 9:34 a.m. stated she was suffering from drug abuse problem, and she had pain to her lower extremity which was not managed properly.</p> <p>Further review of Resident R529's care plan revealed that no baseline care plan had been developed related to the resident's substance abuse disorder including support services for substance abuse disorder.</p> <p>Interview on August 7, 2024, at 2:00 p.m. with Director of Nursing and Assistant Director of Nursing, confirmed that the resident had active drug abuse problem and a base line care plan for substance abuse disorder with services was not developed for Resident R529.</p> <p>28 Pa Code 211.10(d) Resident care policies</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277</p> <p>Based on review of clinical records, observations, and staff interviews, it was determined that the facility failed to ensure comprehensive care plans were developed to address resident care needs for six of 37 residents reviewed (Residents R65, R189, R25, R218, R225, R40).</p> <p>Findings Include:</p> <p>Review of Resident R65's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated June 1, 2024, revealed the resident was cognitively intact.</p> <p>Review of Resident R65's comprehensive care plan dated August 31, 2023, revealed the resident was at risk for falls related to poor safety awareness, weakness, and deconditioning.</p> <p>Observation on August 8, 2024, at 10:00 a.m. revealed Resident R65 had her bed pushed against the wall and no bed rails on the bed.</p> <p>Interview on August 8, 2024, at 10:05 a.m. with Licensed Nurse, Employee E11, confirmed Resident R65 had her bed pushed up against the wall per the resident's preference.</p> <p>Review of Resident R65's comprehensive care plan revealed the resident did not have a care plan in place for preference of the bed being against the wall.</p> <p>Observation on August 5, 2024 at 10:01 a.m. revealed Resident R189 had her bed pushed against the wall and no bed rails on the bed.</p> <p>Review of Resident R189's Minimum Data Set (MDS) completed July 24, 2024 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 0 indicating severe cognitive impairment.</p> <p>Review of Resident R189's care plan revealed the resident did not have a care plan in place for preference of the bed being against the wall.</p> <p>Observation on August 5, 2024 at 10:40 a.m. revealed Resident R25 had his bed pushed against the wall and no bed rails on the bed.</p> <p>Review of Resident R25's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses of: Spinal Stenosis (narrowing of spaces in the spine that results in pressure to nth spinal cord) and Muscle Weakness</p> <p>Review of Resident R25's Minimum Data Set (MDS) completed on July 9, 2024 revealed a Brief Interview for Mental Status (BIMS) score of 2 indicating severe cognitive impairment.</p> <p>Review of Resident R25's care plan revealed the resident did not have a care plan in place for preference of the bed being against the wall.</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 - Some</p>	<p>Observation on August 5, 2024 at 11:11 a.m. revealed Resident R218 and had no bed rails.</p> <p>Review of Resident R218's care plan revealed the resident did not have a care plan in place for preference of the bed being against the wall.</p> <p>The Director of Nursing Employee E2 confirmed on August 6, 2024 at 2:15 p.m. that resident's that have their beds against the wall is because of their preference and the resident's care plan should have the preference included prior to the bed being placed against the wall.</p> <p>Observation with Resident R40 at 10:21 a.m. on August 5, 2024 revealed the Resident R40 stated he was feeling off and dizzy. Observation of Resident R40's room revealed the resident had an oxygen taken that was turned on but the oxygen was not administered to his face.</p> <p>Review of Resident R40's record revealed the resident had diagnoses of: Chronic Obstructive Pulmonary Disease disease process that causes decreased ability of the lungs to perform) and Chronic Respiratory Failure Hypoxia (below-normal level of oxygen in your blood).</p> <p>Interview with licensed nurse Employee E33 at 11:20 a.m. on August 5, 2024 revealed the resident is ordered to have continuous oxygen but is often non-complaint and refuses to use his oxygen.</p> <p>Review of Resident R40's care plan on August 5, 2024 revealed there was no current care plan in place for refusals.</p> <p>Review of Resident R225's record revealed the resident was readmitted to the facility following hospitalization on [DATE].</p> <p>Review of Resident R225 closed clinical record revealed the resident signed on to receive hospice services on May 21, 2024.</p> <p>Review of Resident R225's care plan revealed the resident's care plan did not include hospice services.</p> <p>The above findings were confirmed by the Director of Nursing Employee E2 on August 8, 2024 at 1:11 p.m.</p> <p>28 Pa. Code 211.12(d)(3) Nursing services</p> <p>28 Pa. Code 211.12(d)(5) Nursing services</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471</p> <p>Based on the review of clinical records, facility policies, and interview with staff and residents, it was determined that the facility failed to develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. Facility failed to update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities for two of four residents reviewed for discharge planning process. (Resident R144 and R226)</p> <p>Findings Include:</p> <p>Review of facility policy Discharge Planning: dated January 2019 revealed that To foster the Philosophy of Caring Heart Rehabilitation and Nursing Center, in compliance with Federal and State Regulations and in accordance with HIPAA Regulations, it is the Policy of Caring Heart Rehabilitation and Nursing Center to provide guidelines to evaluate the resident's health status and formulate the best plan of discharge for each resident, utilizing all available community resources.</p> <p>Initial evaluation of resident completed upon admission, document in Social History Assessment.</p> <p>Discharge planning record will be completed in conjunction with Social History Assessment.</p> <p>All discharge plans will be reviewed at care plan conference or as needed. At the time of discharge, a Transition Booklet is provided with all pertinent information needed for continuity of care, including all community resources utilized.</p> <p>Family and resident to be provided with copy of Discharge Summary. Keep on file a list of all known community resources. The list should include (but not necessarily be limited to) the following: Home Health Agencies; Medical Equipment Suppliers; Rehabilitation Centers; Housing for the Elderly; Private Duty Nursing Agencies; Boarding Homes; Personal Care Homes; and Office of Aging Programs.</p> <p>Interview with Resident R144 on August 5, 2024, at 11:00 a.m., stated she wanted to discharge to the community and did not know the status of her discharge.</p> <p>Review of progress note for Resident R144 dated July 16, 2024, revealed that resident's friend was assisting with her discharge. Resident lived alone and the friend reached out to outside agency for waiver services. The outside service agency met with Resident R144 on July 11, 2024. Resident required [NAME] therapy and assistance with everything. Required queuing and recommended 24-hour care.</p> <p>Review of clinical record for Resident R144 revealed that there was no separate discharge planning record created per the facility policy which focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions.</p> <p>(continued on next page)</p>

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of care plan for Resident R144 revealed that the resident had a care plan which stated resident showed potential for discharge and expressed wishes to discharge home. Intervention indicated that discuss with Resident R144 the discharge planning process. The care plan did not identify, resident's support systems, barriers, care needs or factors leading to preventable readmissions. There was no information of outside agencies included in the discharge plan. The care plan was developed on July 2, 2024, and was not updated.</p> <p>Review of social service initial assessment for Resident R226 dated March 28, 2024 revealed that the resident expressed to discharge home with wife and a referral was made to local contact agency.</p> <p>Review of social service progress note dated March 28, 2024, revealed that family would likely to decide upon long term care as they were unable to care for him at his current level. They would like to see what type of progress he makes in therapy first.</p> <p>Review of care plan for Resident R229 revealed that the resident had a care plan which stated resident showed potential for discharge and expressed wishes to discharge home. Intervention indicated that discuss with Resident R144 the discharge planning process and will be discharged to home when rehabilitation/self-care goals are met. The care plan did not identify, resident's support systems, goals, barriers, care needs or factors leading to preventable readmissions. There was no information of outside agencies included in the discharge plan. The care plan was developed on March 22, 2024, and was not updated.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee.</p> <p>28 Pa. Code 211.10 (a) Resident care policies.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395819	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Caring Heart Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6445 Germantown Avenue Philadelphia, PA 19119	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508</p> <p>Based on observation, review of clinical record, review facility policies, and interview with staff, it was determined that the facility failed to ensure that a resident received necessary equipment to maintain resident's functional status in range of motion and mobility for one of 37 residents observed. (Resident R56)</p> <p>Finding:</p> <p>Review of Resident R56's clinical record revealed that Resident R56 was admitted to the facility on [DATE]. Further review of Resident R56' clinical record revealed that Resident R56 had the diagnoses of Aphasia related to Cerebrovascular Disease, Hemiplegia (weakness to one side of the body) Hemiparesis following Cerebral Infarction, General Weakness, Unspecified lack of Coordination.</p> <p>Review of Occupational Therapy discharge note dated April 1, 2024, revealed that prognosis was good with consistent staff followed-through. Further recommendation was Restorative Nursing Program to applied a right palm guard during the morning care and to remove it the right palm guard during p.m. care.</p> <p>Review of physician order revealed an order dated March 27, 2024, for right palm guard during a.m. care, and to take off during p.m. care two times a day.</p> <p>Review of Resident R56's care plan revealed that a restorative nursing plan was developed for the resident to maintain functional ability after therapy goals have been met. The care plan's goal was for the resident to maintain or improve present level of functioning through next review date. The interventions include for the resident to participate in range of motion exercises to maintain/increase mobility. Resident will participate in passive range of motion of all extremities (focusing on right upper extremity exercises) and for Resident R56 to wear a right wrist/hand splint (Palm guard) to prevent contractures. Resident to wear right wrist hand splint on with am care and off with pm care. Check skin integrity each shift.</p> <p>Observation conducted on August 5, 2024, at 1:03 p.m. revealed that Resident R56 was in the dining room in a highbacked wheelchair. Further observation revealed that Resident R56's right hand was in fist. Further there was no palm guard observed on Resident R56's right hand.</p> <p>Observation conducted on August 6, 2024, at 12:50 p.m. revealed that Resident R56 was in the dining room in a highbacked wheelchair. Further observation revealed that Resident R56 did not have a palm guard on his right hand.</p> <p>Observation on Resident R56 conducted on August 8, 2024, at 9:09 a.m. together with Director of Nursing, Employee E2 in the dining room, revealed that Resident R56 was sitting in a highbacked wheelchair. Further Resident R56 did not have a palm guard on his right hand.</p> <p>Interview with Director of Nursing, Employee E2 conducted at the time of the observation confirmed that Resident R56 did not have a palm guard on his right hand.</p> <p>(continued on next page)</p>		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident R56 conducted at the time of the observation in the presence of Director of Nursing, Employee E2 revealed that resident shook his head when asked if staff puts the hand guard in the morning. 28 Pa. Code 201.18(b)(2) Management 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277</p> <p>Based on review of facility documentation, review of clinical records, and staff and resident interviews, it was determined that the facility failed to ensure the resident environment remained free of accident hazards related to falls for three of six residents reviewed (Resident R65, R100, and R380). This failure resulted in actual harm for Resident R65 who sustained a fall out of bed and a laceration to the head requiring staples.</p> <p>Findings Include:</p> <p>Review of Resident R65's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated June 1, 2024, revealed the resident was cognitively intact.</p> <p>Review of Resident R65's comprehensive care plan dated August 31, 2023, revealed the resident was at risk for falls related to poor safety awareness, weakness, and deconditioning.</p> <p>Review of Resident R65's March 2024 physician order summary revealed an order dated March 5, 2024, for bilateral floor mats to be on floor next to bed when resident is in bed.</p> <p>Review of Resident R65's clinical record revealed a nurse's note dated April 8, 2024, that Resident R65 was found on the ground next to bed with a laceration on top of the forehead.</p> <p>Review of facility documentation revealed an incident report dated April 8, 2024, completed by Registered Nurse Supervisor, Employee E8, which revealed Resident R65 sustained an unwitnessed fall on April 8, 2024, at approximately 3:15 a.m. Per the incident report, Resident R65 was found on the ground next to her bed. Resident R65 subsequently sustained a laceration to top of the forehead measuring 2 cm (centimeters) (length) x 1.5 cm (width) x 0.2 cm (depth) and was transferred to the hospital for evaluation. Further review of the incident report revealed the fall mat was not present on the floor at the time of the fall.</p> <p>Review of Resident R65's clinical record revealed Resident R65 was seen by psychiatry on April 8, 2024, where the resident reported she fell out of bed when she was reaching for her call bell.</p> <p>Review of Resident R65's clinical record revealed a skin and wound note dated April 9, 2024, by Nurse Practitioner, Employee E9, which revealed the resident's laceration was treated with four staples during her hospitalization on [DATE].</p> <p>During an interview with Resident R65 on August 8, 2024, at 10:41 a.m. the resident confirmed hitting her head on the floor after falling out of bed on April 8, 2024.</p> <p>Resident R65 was in bed during the interview on August 8, 2024, at 10:41 a.m. and observations revealed fall mat was not on floor next to Resident R65's bed per physician orders.</p> <p>Interview on August 8, 2024, at 10:45 a.m. with Licensed Nurse, Employee E9, confirmed fall mat was not next to Resident R65's bed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on August 8, 2024, at 11:00 a.m. with Licensed Nurse, Employee E11, confirmed Resident R65 hit her head on the floor after falling out of bed on April 8, 2024.</p> <p>The facility failed to ensure that a physician's order for bilateral floor mats were in place while Resident R65 was in bed. This failure resulted in actual harm to Resident R65 who fell from the bed, sustained a laceration to the head and required four sutures.</p> <p>Review of Resident R100's physician orders revealed an order dated June 10, 2024, for bilateral floor mats to be on the floor next to bed when resident is in bed.</p> <p>Review of Resident 100's admission MDS dated [DATE], revealed the resident was cognitively intact and had diagnoses of muscle weakness and lack of coordination.</p> <p>Review of Resident R100's comprehensive care plan dated July 25, 2024, revealed the resident was at risk for falls related to new and unfamiliar environment and sustained a fall on July 24, 2024.</p> <p>Observations on August 6, 2024, at 10:15 a.m. revealed Resident R100 was lying in bed and did not have bilateral floor mats on the floor next to the bed.</p> <p>Follow-up observations on August 6, 2024, at 12:12 p.m. revealed Resident R100 was still in bed and bilateral floor mats were still not in place.</p> <p>Interview on August 6, 2024, at 12:13 p.m. with Licensed Nurse, Employee E12, confirmed Resident R100 did not have bilateral floor mats while the resident was in bed. Observations with Licensed Nurse, Employee E12, revealed no floor mats were available in the resident's room.</p> <p>Clinical record review revealed Resident R380 was readmitted to the facility July 30, 2024 with a diagnosis that included but not limited to Asthma (a condition that affects your airways and makes breathing difficult), Repeated falls, Syncope and collapse (fainting), and Muscle weakness.</p> <p>Further review of clinical records revealed Resident R380 had a significant history of falls, which included two falls in the facility on January 15, 2024 and January 20, 2024.</p> <p>Review of Resident R380's physician orders revealed an order dated July 31, 2024, for bilateral floor mats to be placed on the floor next to bed when resident is in bed.</p> <p>Observations on August 6, 2024, at 10:47 a.m., revealed Resident R380 was lying in bed and did not have bilateral floor mats on the floor next to the bed.</p> <p>Follow-up observation on August 7, at 9:15 am, revealed Resident R380 was lying in bed and bilateral floor mats were still not in place.</p> <p>Interview on August 7, 2024, at 9:27 a.m., with Employee E13, Unit Clerk, confirmed Resident R380 did not have the required bilateral floor mats while the resident was in bed.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee.</p> <p>28 Pa. Code 211.10 (d) Resident Care Policies</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	28 Pa. Code 211.12 (d)(5) Nursing Services.

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277</p> <p>Based on review of facility policy, review of clinical records, and staff interview, it was determined that the facility failed to monitor and modify interventions consistent with the resident's needs to maintain acceptable parameters of nutritional status for four of eight residents reviewed for nutrition (Resident R65, Resident R100, Resident R114, and Resident R69).</p> <p>Findings Include:</p> <p>Review of facility policy Nutrition effective December 2018 revealed resident weights will be obtained to provide a baseline and an ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident. The Dietitian/designee will reassess the nutritional needs and intakes of any resident with a significant weight changed as defined by the Minimum Data Set (MDS - federally mandated resident assessment and care screening). Interventions will be evaluated, documentation made in the electronic medical record, and the resident's plan of care updated.</p> <p>Further review of the facility policy revealed each resident will be weighed upon admission and weekly for 4-weeks during the resident's stay. Each resident will be weighed monthly or more frequently as deemed necessary.</p> <p>Review of Resident R65's Quarterly MDS dated [DATE], revealed the resident was admitted to the facility on [DATE], was cognitively intact, and had a diagnosis of malnutrition (lack of sufficient nutrients in the body).</p> <p>Further review Resident R65's MDS dated [DATE], revealed the resident had a weight loss of 5% or more in the last month or loss of 10% or more in the last six months and was not on a physician prescribed weight loss regimen.</p> <p>Review of Resident R65's comprehensive care plan dated September 14, 2023, revealed the resident was at nutrition/hydration risk. Interventions dated September 14, 2024, included to monitor/record/report signs and symptoms of malnutrition such as muscle wasting and significant weight loss: 3 pounds in 1 week, greater than 5% in one month, greater than 7.5% in 3 months, and greater than 10% in 6 months.</p> <p>Review of Resident R65's nutrition quarterly assessment dated [DATE], revealed the resident was ordered oral nutrition supplements to promote weight gain. Goals for Resident R65 was for no weight loss through the next review.</p> <p>Review of Resident R65's weight history revealed the resident weighed 95 pounds on March 7, 2024, and 89 pounds on April 15, 2024, reflecting a 6-pound and 6.32% significant weight loss in one month.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R65's entire clinical record revealed no documented evidence the Registered Dietitian was made aware. Further review of the clinical record revealed no documented evidence the Registered Dietitian addressed Resident R65's significant weight loss and reviewed, and modified interventions consistent with the resident needs.</p> <p>Continued review of Resident R65's weight history revealed the resident's weight continued to trend down to 74-pounds on May 20, 2024, reflecting a 15-pound and 16.8% weight loss in one month.</p> <p>Review of Resident R65's entire clinical record revealed no documented evidence the Registered Dietitian was made aware. Further review of the clinical record revealed no documented evidence the Registered Dietitian addressed Resident R65's significant weight loss and reviewed, and modified interventions consistent with the resident needs.</p> <p>Further review of Resident 65's weight history revealed the resident's weight continued to trend down to 71-pounds on June 3, 2024.</p> <p>Review of Resident R65's entire clinical record revealed the Dietitian did not address the resident's weight loss starting from March 7, 2024, until June 18, 2024.</p> <p>Further review of Resident R65's clinical record revealed the resident continued to have a weight loss trend to 67-pounds on July 4, 2024, reflecting a 4-pound and 5.6% significant weight loss in one month.</p> <p>Review of Resident R100's admission MDS dated [DATE], revealed the resident was admitted to the facility on [DATE], was cognitively intact, and had a diagnosis of Type 2 Diabetes Mellitus (the body's inability to produce sufficient insulin, a hormone that helps the body use glucose for energy and manage blood sugar levels, causing high blood sugars).</p> <p>Review of Resident R100's comprehensive care plan dated June 17, 2024, revealed the resident was at potential nutrition risk related to history of weight loss. Interventions dated June 17, 2024, included to monitor/record/report signs and symptoms of malnutrition such as muscle wasting and significant weight loss.</p> <p>Review of Resident R100's comprehensive nutrition assessment dated [DATE], revealed the resident was at risk for malnutrition and had inadequate oral intake due to food insecurity prior to admission as evidenced by underweight body mass index (BMI - medical screening tool that measures the ratio of your height to your weight to estimate the amount of body fat you have) and resident reported weight loss. Nutrition goals set for Resident R100 included PO (by mouth) intakes greater than 50%.</p> <p>Interview on August 6, 2024, at 10:15 a.m. Resident R100 reported poor meal intakes due to difficulties chewing and swallowing.</p> <p>Review of Resident R100's weight history revealed the resident was weighed at 127.4-pounds on June 10, 2024. Further review of the resident's clinical record revealed no documented evidence a July 2024 weight was obtained.</p> <p>Interview on August 6, 2024, at 10:58 a.m. with Licensed Nurse, Employee E23, confirmed no July weight was available for Resident R100.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R100's meal intakes from July 8, 2024, through August 5, 2024, revealed the resident ate 50% or less of 18 meals and refused 10 meals.</p> <p>Continued review of Resident R100's electronic medical record revealed no documented evidence that an August weight was yet available as of August 6, 2024.</p> <p>Interview on August 6, 2024, at 10:55 a.m. Licensed Nurse, Employee E11, provided state surveyor with a paper copy of Weights Worksheet dated August 2024. Review of the weight's worksheet revealed Resident R100 was weighed at 105.6 pounds reflecting a 21.8-pound and 17% significant weight loss since June 10, 2024.</p> <p>Review of Resident R100's electronic medical record revealed the resident was re-weighed on August 7, 2024, at 106-pounds confirming the significant weight loss.</p> <p>Review of Resident R100's entire clinical record revealed no documented evidence the Dietitian was made aware of the resident's poor to variable intakes. Further review of the clinical record revealed no documented evidence the Registered Dietitian monitored and modified interventions consistent with the resident's assessed needs to maintain acceptable parameters of nutritional status.</p> <p>Review of Resident R114's comprehensive MDS dated [DATE], revealed the resident was admitted to the facility on [DATE], had moderate cognitive impairment, and had a diagnosis of psychotic disorder.</p> <p>Review of Resident R114's comprehensive care plan dated April 10, 2020, revealed the resident was at potential nutrition risk related to dysphagia (difficulty swallowing) and weight loss.</p> <p>Review of Resident R114's comprehensive nutrition assessment dated [DATE], revealed the resident was at risk for malnutrition. Interventions included to monitor monthly weights and follow-up and reassess as needed.</p> <p>Review of Resident R114's weight history revealed no documented evidence a June 2024 weight was obtained for the resident.</p> <p>Interview on August 8, 2024, at 10:38 a.m. with the Registered Dietitian, Employee E5, confirmed no further information was available regarding Resident R65, R100, and R114.</p> <p>Observation of Resident R69's room conducted on August 6, 2024, at 9:35 am, revealed 2 unopened containers of ensure and one opened container of Ensure half full, on top of Resident R69's overhead table.</p> <p>Follow-up observation of Resident R69's room conducted on August 7, 2024, at 11:27 am, revealed 2 unopened containers of Ensure on top of Resident R69's overhead table.</p> <p>Review of Resident R69's weight record revealed that on July 16, 2024, the weight was 136.4 lbs. (pounds), on June 6, 2024, the weight was 134.8 lbs., March 12, 2024, the weight was 148.1 lbs., a 8.98% in 3 months (from June 6, 2024 to March 12, 2024)</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R69's care plan revealed that Resident R69 has nutritional problem or potential nutritional problem related to weight loss, fair intake, low BMI, compromised skin, dependent for feeding. Intervention was as follow: Monitor/record/report to MD as needed any signs and symptoms of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 3lbs in 1 week, more than 5% in 1 month, more than 7.5% in 3 months, more than 10% in 6 months.</p> <p>Further review of Resident R69's clinical record reveled that there was no documented evidence that the weight loss was addressed, review of clinical record revealed that there was no nutrition assessment completed during the time of weight loss</p> <p>Interview with Dietitian Employee E5 conducted on August 7, 2024, at 1:24pm, confirmed that Resident R69 had more than 7.5% weight loss in three months from (from June 6, 2024, to March 12, 2024).</p> <p>Further interview with Employee E5 confirmed that there was no documented evidence in Resident R69's clinical record that Resident R69's weight loss was addressed.</p> <p>28 Pa. Code 211.10 (c) Resident care policies</p> <p>28 Pa. Code 211.12 (d)(3) 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471</p> <p>Based on observations, review of clinical records, facility policies and procedures, and interviews with staff and resident, it was determined that the facility failed to provide adequate treatment and care for a PICC (Peripherally Inserted Central Line Catheter) in accordance with professional standards of practice for one of one resident with PICC line reviewed (Resident R529).</p> <p>Findings include:</p> <p>Review of facility policy, Care of the Peripherally Inserted Central Catheter dated December 2023, revealed that Measure external PICC catheter on admission and note length with every dressing change. Place length as supplemental documentation in the order sign off. Transparent dressings must be labeled and changed every 7 days or more frequently (prn) if the dressing is damp, loose, soiled or if any damage occurs.</p> <p>Review of clinical record for Resident R13 revealed that the resident was admitted to the facility on [DATE].</p> <p>Observation of Resident R529 on August 6, 2024, at 10:00 a.m., revealed that the resident had a right upper extremity PICC line insertion. There was no documentation on the dressing to indicate the date and time the dressing last changed.</p> <p>Review Resident R529's hospital record dated July 29, 2024, revealed that the PICC line was placed on July 29, 2024.</p> <p>Review Resident R529's physician order dated August 5, 2024, revealed an order to Change dressing, extension set and cap, weekly and as needed every day shift, every Monday.</p> <p>A review of the treatment administration record (TAR) for the month of August 2024 indicated that the dressing change was signed off as completed on August 3, 2024, and August 5, 2024. Continued review of the TAR revealed that the PICC line assessment such as external catheter length and arm circumference measurement was also not completed as ordered by the physician with each dressing change.</p> <p>On August 6, 2024, at 10:00 a.m., Resident R529 stated the dressing was last changed in the hospital. Facility did not change the dressing since the admission and there was no dressing change completed on August 3 and August 5, 2024.</p> <p>Review of progress note for Resident R529 dated August 6, 2024, revealed that the PICC line dressing was changed on August 6, 2024, for 3p.m -11p.m. shift. There was no documentation of this dressing change in the TAR. There was no external catheter length measurement documented with this dressing change.</p> <p>An interview with Director of Nursing, Employee E2, on August 7, 2024, at 2:00 p.m confirmed that that the PICC line dressing change, assessment and monitoring was not completed for Resident R529 as ordered by the physician and according to the facility protocol.</p> <p>(continued on next page)</p>		

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

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code: 211.10 (c) Resident care policies 28 Pa. Code: 211.10 (d) Resident care policies 28 Pa. Code: 211.12 (d)(1) Nursing services 28 Pa. Code: 211.12(d)(5) Nursing services

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>41471</p> <p>Based on observation, review of posted daily nurse staffing data, and staff interviews, it was determined that the facility failed to ensure nursing staffing information was posted on a prominent place readily accessible to residents on three of three resident floors (Second, Third and Fourth floors).</p> <p>Findings include:</p> <p>Observation of the facility on August 5, 2024, and again on August 6, 2024, at 10:00 a.m. revealed the facility did not post the nurse staffing data daily on the Second, Third and Fourth floors in a prominent place that was readily accessible to residents.</p> <p>It was observed that the facility posted the staffing on the first-floor lobby area. Continued observation revealed that the third-floor nursing unit was a locked unit and it required staff to assist the residents to access the elevator or the stairs which made it hard for access the staffing data without staff assistance.</p> <p>These findings were reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on August 7, 2024, at 2:00 p.m.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 211.12(d)(1) 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277</p> <p>Based on review of facility policy and review of clinical records, it was determined that the facility failed to provide pharmaceutical services to assure the acquiring and administering of medications to meet the needs of each resident for one of 37 residents reviewed (Resident R100).</p> <p>Findings Include:</p> <p>Review of facility policy Unavailable Medications revised December 2023 revealed staff shall take immediate action when it is known that a medication is unavailable and determine reason for unavailability, length of time med is unavailable, and what efforts have been attempted by the facility or pharmacy provider to obtain the medication. Staff should notify the physician when a medication is unavailable. Staff should further obtain alternative treatment orders and/or specific orders for monitoring resident while the medication is on hold.</p> <p>Review of Resident R100's admission Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated June 13, 2024, revealed the resident was admitted to the facility on [DATE], was cognitively intact, and had a diagnosis of fractures and other multiple trauma.</p> <p>Review of Resident R100's physician order summary revealed an order dated June 7, 2024, for Enoxaparin injection (medication that helps prevent blood clots) 40 milligrams one time a day for anticoagulant therapy (decrease blood clotting ability).</p> <p>Review of Resident R100's medication administration record revealed the Enoxaparin injection was not administered on 06/20/2024 and 06/21/2024.</p> <p>Review of Resident R100's clinical record revealed an order administration note dated June 20, 2024, that the Enoxaparin injection medication was on order with no further information.</p> <p>Continued review of Resident R100's clinical record revealed an order administration note dated June 21, 2024, that the nurse was awaiting pharmacy delivery of the Enoxaparin injection with no further information.</p> <p>Further review of Resident R100's clinical record revealed no documented evidence that the physician was made aware of the missed doses, that an alternate treatment was requested, or specific orders for monitoring while the medication was unavailable. Review of the clinical record revealed no documented evidence the licensed nurse determined the reason for unavailability, length of time medication is unavailable, and what efforts were attempted to obtain the medication.</p> <p>28 Pa. Code 211.9 (a)(1) Pharmacy Services.</p> <p>28 Pa. Code 211.9 (d) Pharmacy Services.</p> <p>28 Pa. Code 211.12 (d)(1) Nursing Services.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>39343</p> <p>Based on observations, review of clinical records, and interviews with facility staff, it was determined that the facility failed to ensure that it was free of medication error rate of five percent or greater for two of six residents observed during medication administration. (Resident R135 and Resident R6)</p> <p>Findings include:</p> <p>On August 6, 2024, 9:11 a.m., observed that Employee E7, a Licensed Nurse, administered to Resident R135, the medicine, Fluticasone Propionate Nasal Suspension 50 MCG/ACT, one spray to each nostril.</p> <p>Review of physician order for Resident R135, dated May 20, 2024, revealed an order to administer Fluticasone Propionate Nasal Suspension 50 MCG/ACT, two sprays to alternating nostrils, one time a day for asthma.</p> <p>At the time of the observation, interviewed with Licensed nurse Employee E7, confirmed the above findings.</p> <p>On August 6, 2024, 9:11 a.m., observed that Licensed nurse, Employee E7, did not administer to Resident R135, the physician ordered buPROPion HCl Oral Tablet 75 MG (Bupropion HCl), Give 37.5 mg by mouth one time a day after breakfast. Employee E7 stated that the medicine buPROPion HCl Oral Tablet 75 MG, was not available at that time. (Bupropion hydrochloride (HCL) is an antidepressant used to treat a variety of conditions, including depression and other mental/mood disorders;</p> <p>On August 6, 2024, 9:37 a.m., observed that Licensed nurse, Employee E7, a was going to administer by crushing the following medications to Resident R63, by mouth; but was prevented the administration of those medicines by crushing: glipiZIDE ER Oral Tablet Extended Release, 10 MG (Glipizide), one tablet by mouth; Magnesium Lactate Oral Tablet Extended Release 84 MG (7MEQ) (Magnesium Lactate), one tablet by mouth; 3 Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 50 MG (Metoprolol Succinate) one tablet by mouth.</p> <p>Review of literature revealed as follows: Crushing an Extended-Release preparation may change the drug release characteristics, with the potential for an unintended large bolus dose being delivered rather than controlled release over the intended timescale. The consequence of this would be for a potentially toxic dose of medication to be delivered following administration with an increased risk of adverse effects. While there is the risk of initial overdosing of drug, there will be under dosing at later times which could result in a lack of clinical efficacy. (Article: Pharmaceutical Issues when Crushing, Opening or Splitting Oral Dosage Forms; June 2011 Introduction by Royal Pharmaceutical Society in https://www.rpharms.com).</p> <p>On August 6, 2024, 9:43 a.m., observed that Licensed nurse, Employee E7, administered Magnesium Oxide 400 mg tablet by mouth to Resident R63.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of physician order for Resident R63, dated April 7, 2024, revealed an order to administer Magnesium Lactate Oral Tablet Extended Release 84 MG (7MEQ) (Magnesium Lactate), Give 1 tablet by mouth for hypomagnesemia.</p> <p>(Review of literature revealed that Magnesium Lactate, where Magnesium is bound to Lactic Acid, has been shown to be at least twice as absorbable than Magnesium Oxide).</p> <p>At the time of the observation, interviewed with Employee E7 confirmed the above findings.</p> <p>The facility incurred a medication error rate of 19.23%.</p> <p>Pa Code:211.12(d)(1)(2)(5) Nursing Services.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>41471</p> <p>Based on review of clinical records, review of facility policy, observation, and staff and resident interview, it was determined that the facility failed to ensure that all drugs and biologicals were stored in accordance with professional standards for one of four floors reviewed (fourth floor) and two of 37 residents reviewed (Resident R379 and Resident R528).</p> <p>Findings include:</p> <p>Observation of the Resident R528's room conducted on August 5, 2024, at 10:32 am during the tour of the 2nd floor revealed a medication cup on top of Resident R528's breakfast tray. There were six pills in the cup.</p> <p>Interview with Resident R528's son on August 5, 2024, at 10:32 am stated the medication cup with medication was on top the bed near the foot of the bed when he came in the morning, he stated he took it and placed it in the breakfast tray so that the resident would not spill it.</p> <p>Interview with Employee E23 on August 5, 2024, at 10:35 a.m. stated resident was not supposed to self-administer the medication and the medications was not the morning medications she administered, it may be from previous shift.</p> <p>Observation of the fourth-floor unit conducted on August 5, 2024, at 10:29 am revealed that the unit manager's office door was wide open. Further, a stack of medication blister pack with medications in them was on top of a file cabinet inside the office in close proximity to the open door.</p> <p>Interview with Fourth Floor Unit Manager Employee E19 co ducted on August 5, 2024, at 11:27 am confirmed that her office was open and that there was a stack of blister packs with medication in them was on top of a file cabinet inside the office in close proximity to the open door.</p> <p>Observation of the Resident R379's room conducted on August 5, 2024, at 10:52 am during the tour of the 4th floor revealed a medication cup on top of Resident R379's overhead table. Further, a half of a large white tablet was inside the cup.</p> <p>Further observation revealed a Symbicort inhaler was also on top of the overhead table.</p> <p>Interview with Resident R379 conducted at the time of the observation revealed that the white tablet was a nicotine tablet that he cut himself because it was too big to swallow. Further Resident R379 also confirmed that the Symbicort inhaler was his.</p> <p>Further interview with Resident R379 revealed that the nurse gave him the medications about an hour ago and left the medications with him.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R379's clinical record revealed a physician's order dated May 18, 2024, for Symbicort Inhalation Aerosol 160-4.5 MCG/ACT (Budesonide-Formoterol Fumarate Dihydrate) 2 puff inhale orally two times a day for COPD (Chronic Obstructive Pulmonary Disease)</p> <p>Further review of Resident R379's clinical record revealed a physician's order dated July 19, 2024, for: Nicotine Polacrilex Mouth/Throat Gum 4 MG (Nicotine Polacrilex) Give 4 mg by mouth every 6 hours for smoking cessation for 4 months for 4 Months</p> <p>28 Pa. Code 201.8(b)(l) Management</p> <p>28 Pa. Code 211.12(d) Nursing services</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277</p> <p>Based on review of facility documentation, observations, and staff and resident interviews, it was determined that the facility failed to ensure that menus were followed to meet the daily nutritional needs and preferences of the residents for six of six nursing units and three of 29 residents reviewed for dining observations (Resident R100, R114, and R76).</p> <p>Findings Include:</p> <p>Review of the facility menu extension sheets for the week of 08/05/2024 revealed milk is part of the menu and should be provided with breakfast, lunch, and dinner.</p> <p>Observation made of the lunch meal on August 5, 2024 at 12:05 p.m. on the third floor in the dining room. The lunch menu posted listed the following for the meal: fish sticks, garden rice, parsley carrots, fruit crisp, and milk.</p> <p>Review of 19 resident trays during the lunch meal revealed none of the residents were provided milk on their trays. Interview with nurse aide, Employee E15 at 12:40 p.m. revealed residents aren't always given milk on their trays. Employee E15 stated at times the milk is substituted with water or milk.</p> <p>Review of 19 residents revealed all resident were given mixed fruit or applesauce in place of fruit crisp.</p> <p>Further review of the facility menu revealed cherry cheesecake was the dessert for lunch on August 6, 2024.</p> <p>Observations of the tray line on August 6, 2024, at 11:45 a.m. revealed cheesecake dessert portions offered with lunch were plain and not cherry cheesecake per the menu.</p> <p>A test tray was conducted on August 6, 2024, at 12:00 p.m. with the Food Service Director, Employee E4, which revealed a plain slice of cheesecake was offered with the test tray. The Food Service Director, Employee E4, confirmed cherry cheesecake was not offered because cherries were unavailable for ordering and no substitutions were available for purchase.</p> <p>Further interview on August 6, 2024, at 12:00 p.m. with the Food Service Director, Employee E4, revealed no notification was made to the residents to make them aware of changes to the menu. State surveyor requested supporting documentation that cherries were unavailable for purchase, and further, that other fruits were unavailable as a substitute.</p> <p>No documentation was provided by the end of survey on August 8, 2024, to support unavailability of food items to ensure the menu was followed.</p> <p>Review of nutrition assessment for Resident R114 dated April 15, 2024, revealed resident requests whole milk with all meals.</p> <p>(continued on next page)</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of nutrition assessment for Resident R100 dated June 11, 2024, revealed resident requested milk on all trays.</p> <p>Observations on August 6, 2024, at 12:57 p.m. revealed Resident R100's lunch ticket specified that the resident was to be provided with whole milk with lunch. Further observations revealed Resident R100 was not provided with whole milk per his nutrition assessment and the planned menu.</p> <p>Interview on August 6, 2024, at 12:57, with Licensed Nurse, Employee E9, confirmed Resident R100 should receive what is listed on the meal ticket and did not receive whole milk with lunch.</p> <p>Observations on August 6, 2024, at 1:05 p.m. revealed Resident R114's lunch ticket specified the resident was to be provided with whole milk with lunch. Further observations revealed Resident R114 was not provided with whole milk per his nutrition assessment and the planned menu.</p> <p>Interview on August 6, 2024, at 1:05 p.m. with Nurse Aides, Employee E24 and E25, confirmed Resident R114 did not receive whole milk with lunch.</p> <p>Review of Resident R76's physician order summary revealed a diet order dated February 7, 2024, for a pureed textured diet (foods with a smooth, pudding-like consistency).</p> <p>Review of Resident R76's comprehensive nutrition assessment dated [DATE], revealed the resident was at risk for malnutrition (lack of sufficient nutrients in the body) and had a need for texture modified diet related to dysphagia (difficulty swallowing). Interventions included to provide diet as ordered with a goal of 25-50% meal completion.</p> <p>Observations on August 7, 2024, at 9:40 a.m. revealed Resident R76's meal ticket specified to provide pureed pancakes, pureed cereal, and pureed sausage for breakfast. Observations revealed Resident R76 was provided with only two yogurts on the breakfast tray and nothing else.</p> <p>Interview on August 7, 2024, at 9:57 a.m. with Nurse Aide, Employee E26, confirmed Resident R76 was only provided with yogurt for breakfast. Further interview with Nurse Aide, Employee E26, revealed Resident R76 has a good appetite and would eat the pureed breakfast items per the meal ticket. Nurse aide, Employee E26, reported the kitchen will also only send yogurt for lunch instead of what is ordered per the menu.</p> <p>28 Pa. Code 211.6 (a) Dietary 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>43277</p> <p>Based on review of facility policy, observations, and interviews with staff and residents, it was determined that the facility did not ensure that food was stored, prepared, and served in accordance with professional standards for food service safety.</p> <p>Findings Include:</p> <p>Review of facility policy Food Storage undated revealed plastic containers with tight-fitting covers must be used for storing grain products. Leftover food will be stored in covered containers and wrapped carefully and securely. Each item will be clearly labeled and dated before being refrigerated. Leftover food is used within 7 days or discarded.</p> <p>An initial tour of the Food Service Department conducted on August 5, 2024, at 9:42 a.m. with the Food Service Director, Employee E4, revealed the following:</p> <p>Dietary employees were observed using the dish machine to clean utensils, cups, plates, meal trays, and lids from the breakfast meal. Based on review of the dish washer water temperatures, the dish washer should have been using chemicals for proper sanitation.</p> <p>Observations of the operation of the dish machine with the Food Service Director, Employee E4, revealed that the chemical that was dispensing into the dish machine was not registering when tested .</p> <p>Observations revealed that the dietary staff were not operating the dish machine properly. The chemical was not dispensing according to manufacturer's directions into the dish machine.</p> <p>Observations under the coffee machine revealed the shelves had multiple, brown coffee stains that were sticky to touch and a fruit fly present.</p> <p>Observations of the dry storage area revealed the following:</p> <p>An open container of rice that was open to air and not properly stored in an air-tight container; a stainless-steel mixing bowl with leftover stuffing that was dated June 15, 2024. Food Service Director, Employee E4, was unable to say whether this was the use by or stored date. Continued observations revealed multiple packages of cookies with an expiration date of August 31, 2023. There was a bottle of Worcestershire sauce with drippings on the outside of the bottle making it sticky to touch.</p> <p>Observations revealed a prep sink next to the stove that had broken tile beneath it and a pool of stagnant water.</p> <p>Observations of the walk-in refrigeration revealed the shelves were sticky to touch and the floors had significant build up of food and debris along the perimeter.</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>Continued observations of the walk-in refrigeration revealed a tray of lasagna with a use by date of July 24, 2024. A container of pickles, not in its original packaging, with a date of June 26, 2024. Food Service Director, Employee E4, was unable to say whether this was the use by or stored date. Continued observations revealed bottles of Italian and ranch dressing with drippings on the outside of the bottle making it sticky to touch. A bottle of tarter sauce with a date of 9/11 (unsure if use by or open date) that had a black visible build-up along the perimeter of the lid.</p> <p>Observations of the walk-in refrigeration where produce is kept revealed a stainless-steel container of leftover raw bell peppers with a date of August 1, 2024. Food Service Director, Employee E4, was unable to say whether this was the use by or stored date.</p> <p>Observations of the reach-in freezer revealed a single serve ice-cream with a use by date of January 2024.</p> <p>Observations of the microwave revealed significant food build-up on the inside that required wiping down.</p> <p>Observations on August 5, 2024, at 12:00 p.m. revealed dietary staff were setting up tray line for the lunch time meal. Dietary staff were observed to be using paper plates and paper utensils, however, were using the meal trays and lids that were used for breakfast.</p> <p>Interview on August 5, 2024, at 12:00 p.m. with the Food Service Director, Employee E4, revealed the food service department did not have paper trays to use. Food Service Director, Employee E4, confirmed the meal trays and lids were not properly cleaned and sanitized before use for the lunch time meal.</p> <p>28 Pa. Code 201.14 (a) Responsibility of Licensee.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395819	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Caring Heart Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6445 Germantown Avenue Philadelphia, PA 19119	

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<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277</p> <p>Based on review of facility documentation, review of clinical records, and resident interviews, it was determined that the facility failed to submit complete and accurate information to the State Survey Agency regarding a resident fall and subsequent transfer to the hospital for one of six residents reviewed for falls incidents (Resident R65).</p> <p>Findings Include:</p> <p>Review of Resident R65's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated June 1, 2024, revealed the resident was cognitively intact.</p> <p>Review of facility reported documentation submitted to the Department of Health on April 8, 2024, revealed that on April 8, 2024, Resident R65, had a fall in her room and sustained an open area to the forehead. Continued review of the facility reported documentation revealed safety measures were in place at the time of the fall. Resident R65 was transferred to the hospital for evaluation and returned. Per the facility reported documentation, the hospital computed tomography (CT - imaging test that helps healthcare providers detect injuries) scan of head and spine showed no acute findings.</p> <p>During an onsite review of the facility reported incident on August 8, 2024, the surveyor identified that the facility did not submit complete and accurate information regarding Resident R65's fall pn April 8, 2024.</p> <p>Review of Resident R65's physician order summary revealed an order dated March 5, 2024, for bilateral floor mats to be on floor next to bed when resident is in bed.</p> <p>Review of facility documentation revealed an incident report dated April 8, 2024, completed by Registered Nurse Supervisor, Employee E8, which revealed Resident R65 sustained an unwitnessed fall on April 8, 2024, at approximately 3:15 a.m. Resident R65 was found on the ground next to her bed. Resident R65 subsequently sustained a laceration to top of the forehead measuring 2 cm (centimeters) (length) x 1.5 cm (width) x 0.2 cm (depth) and was transferred to the hospital for evaluation. Further review of the incident report revealed the fall mat was not present on the floor at the time of the fall.</p> <p>Review of Resident R65's clinical record revealed Resident R65 was seen by psychiatry on April 8, 2024, where the resident reported she fell out of bed when she was reaching for her call bell.</p> <p>Review of Resident R65's clinical record revealed a skin and wound note dated April 9, 2024, by Nurse Practitioner, Employee E9, which revealed the resident's laceration was treated with four staples during her hospitalization on [DATE].</p> <p>During an interview with Resident R65 on August 8, 2024, at 10:41 a.m. the resident confirmed hitting her head on the floor after falling out of bed on April 8, 2024.</p> <p>(continued on next page)</p>

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<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility failed to include pertinent, detailed information to the State Survey Agency that contributed to Resident R65's injury at the time of the fall. Further, the facility failed to include that the laceration Resident R65 sustained to the head subsequently required staples.</p> <p>28 Pa Code: 201.14 (a) Responsibility of licensee.</p> <p>28 Pa Code: 201.18 (b)(1) Management.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Keep all essential equipment working safely.</p> <p>43277</p> <p>Based on review of facility policy, review of facility documentation, observation, and staff interview it was determined that the facility failed to ensure that essential equipment was maintained in safe and operating conditions related to the dish machine in the main kitchen and handwashing sink in the laundry area.</p> <p>Findings Include:</p> <p>Review of facility policy Sanitation of Dishes/Dish Machine undated, revealed for a high temperature dish washer, wash temperature should be 150-165 degrees Fahrenheit, and final rinse temperature should be 180 degrees Fahrenheit.</p> <p>Further review of facility policy revealed for a low temperature dish washer the wash temperature should be 120 degrees Fahrenheit and the sanitation should reach at least 50 ppm (parts per million).</p> <p>An initial tour of the Food Service Department conducted on August 5, 2024, at 9:42 a.m. with the Food Service Director, Employee E4, revealed the following:</p> <p>Dietary employees were observed using the dish machine to clean utensils, cups, plates, meal trays, and lids from the breakfast meal.</p> <p>Interview with the Food Service Director, Employee E4, revealed that the dish washer can be used as a heat sanitation (final rinse temperatures should reach 180 degrees Fahrenheit) or chemical sanitation. Observations revealed the wash temperature was 120 degrees Fahrenheit, and the temperature of the final rinse water was only 90 degrees Fahrenheit, subsequently the dish machine should have been using chemicals to sanitize.</p> <p>Observations of the operation of the dish machine with the Food Service Director, Employee E4, revealed that the chemical that was dispensing into the dish machine was not registering when tested .</p> <p>The Food Service Director, Employee E4, reported that the chemical being used was low temperature machine sanitizer.</p> <p>Review of the Manufacturer's recommendations revealed that it is a chlorine sanitizer and chlorine levels should be tested with a test kit to be sure chlorine levels do not drop below 50 ppm. Below 50 ppm sanitization may be incomplete.</p> <p>Observations revealed that the dietary staff were not operating the dish machine properly. The chemical was not dispensing according to manufacturer's directions into the dish machine.</p> <p>Interview with the Food Service Director, Employee E4, confirmed the high temperature sanitation has not been working, because the booster (essential piece of the dish machine to boost water temperatures) has been broken for a couple months. Food Service Director, Employee E4, was unable to give specific date.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Continued interview with the Food Service Director, Employee E4, revealed dietary staff should be logging the sanitizing solution with each use of the dish machine.</p> <p>Review of the log for the dish machine for August 2024 revealed only temperatures were being monitored, not the sanitizing solution.</p> <p>Temperatures on the August 2024 dish machine log from 08/01/2024 through 08/04/2024 revealed the final rinse water temperature was being documented as 180 degrees or higher. Interview with the Food Service Director, Employee E4, revealed these were inaccurate and falsely documented since the booster for the dish machine has been broken for months, it is not possible that the water would be able to reach those temperatures.</p> <p>Interviews on August 5, 2024, between 9:45 a.m. and 1:15 p.m. with dietary aides, Employees E28, E29, E30, E31, and E32, revealed no education was given regarding how to check sanitizing levels on the dish machine.</p> <p>Interview with the Food Service Director, Employee E4, confirmed no education was done with dietary staff on how to test the sanitizer levels on the dish machine.</p> <p>Follow-up interview on August 5, 2024, at 1:56 p.m. with Food Service Director, Employee E4, revealed the servicing company came out to assess dish machine and confirmed the tubing for the sanitizer had come off and was subsequently not dispensing sanitizer solution into the dish machine.</p> <p>Observation of the laundry area conducted on August 6, 2024, at 11:20 am together with Director of Maintenance Employee E16 revealed a sink located in the soiled section of the laundry room. Further, the sink in soiled area was covered in plastic.</p> <p>Further observation of the laundry room revealed that there were no hand sanitizers available to staff to use after handling soiled linens, clothing, and other items</p> <p>Interview with Director of Maintenance, Employee E16 conducted at the time of the observation revealed that the sink was broken. Further, Employee E16 revealed that the sink has been broken for a while.</p> <p>Further interview with Director of Maintenance, Employee 16 confirmed that there were no other ways for employees to wash their hands after handling soiled linens and other soiled item.</p> <p>Interview with, laundry workers, Employee 21 and Employee E22 conducted at the time of the observation revealed that sink has been broken since for a while now.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471</p> <p>Based on observations, and interviews with residents, it was determined that the facility failed to maintain an effective pest control program in the resident care areas for two resident rooms units reviewed. (Second floor and third floor)</p> <p>Findings include:</p> <p>Observation of Resident room [ROOM NUMBER] on August 5, 2024, at 10:52 a.m. revealed that there was flies in the room. Interview with Employee E22, House keeping staff confirmed the finding.</p> <p>Observation of the first-floor conference room on August 6, 2024, at 2: 30 p.m. with facility administration including Administrator and Director of Nursing reveal ed that there was flies in the room.</p> <p>Observation of facility second floor nursing area revealed that there were flies in the hall way.</p> <p>Review of the pest control log dated July 10, 2024 reealed that there was flies reported in room [ROOM NUMBER].</p> <p>Review of the pest control log dated July 16, 2024 reealed that there was fruit flies reported on 5th floor</p> <p>Review of the pest control log dated July 21, 2024 reealed that there was flies reported in room [ROOM NUMBER] A and B.</p> <p>Review of the pest control log dated July 21, 2024 reealed that there was flies reported in room [ROOM NUMBER].</p> <p>Review of the pest control log dated July 30, 2024 reealed that there was flies reported in room [ROOM NUMBER].</p> <p>Review of the pest control log dated July 31, 2024 reealed that there was flies reported in room [ROOM NUMBER].</p> <p>Review of weekly pest control company report dated July 8, 2024 reealed no evidence of fly sighting or treatment targeting flies. Report indicated Checked logbooks no reports.</p> <p>Review of weekly pest control company report dated July 15, 2024 reealed no evidence of fly sighting or treatment targeting flies.</p> <p>Review of weekly pest control company report dated July 22, 2024 reealed no evidence of fly sighting or treatment targeting flies.</p> <p>Review of weekly pest control company report dated July 29, 2024 reealed Checked logbooks no reports.</p> <p>(continued on next page)</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observations in the main kitchen on August 5, 2024, during the initial tour at 9:45 a.m. with the Food Service Director, Employee E4, revealed the following:</p> <p>Observations under the coffee machine revealed the shelves had multiple, brown coffee stains that were sticky to touch and a fruit fly present.</p> <p>Observations revealed a prep sink next to the stove that had broken tile beneath it and a pool of stagnant water.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee.</p>