

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395950	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER Centennial Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4400 West Girard Avenue Philadelphia, PA 19104	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews with resident and facility staff, review of resident and facility documentation and policy it was determined that the facility did not ensure one resident was free from verbal and mental abuse during two incidents for 39 resident records reviewed (Resident R116). Findings include: Review of the facility policy and procedure. Last revised on October 2022, for Abuse of Residents states. It the facility's policy that acts of physical, verbal, psychological and financial abuse directed against residents are absolutely prohibited. The policy defines verbal abuse as to any use of oral written or gestured language that included disparaging and derogatory terms to residents and their families, or within hearing distance to describe residents, regardless of their age, ability to comprehend or disability. The same policy states, Mental abuse, includes, but not limited to resident humiliation intimidation threatening demeanor, harassment and threats of punishment or withholding a treatment, services, or privileges. Resident R116 was admitted to the facility on [DATE], with diagnosed with Multiple Sclerosis (an immune system eats away at the protective covering of nerves), Fibromyalgia (a chronic condition causing widespread musculoskeletal pain, and fatigue), bipolar (mood swings), and clinically documented alert, oriented and had the cognitive ability to make autonomous choices. Review of an event report received from the Director of Nursing (DON) dated January 2, 2025, revealed reported staff to resident verbal abuse between Resident R116 and a Nurse Aide (NA), Employee E3. The resident reported the NA was was rude accusing the resident of ringing the call bell for her roommate. The resident stated that the aide's tone of voice was rude, and aggressive at the time of the encounter. Review of the facility investigation with Resident R116 on August 15, 2025, confirmed on December 31, 2024, at 7:30 p. m. Resident R116, heard NA, E3 talking to R116's roommate in a very Rude and aggressive manner because the roommate's call light was on. Resident R116 explained that the resident's, roommate, Resident R159 tried telling the aide she didn't remember turning on the call bell. Resident R116 said the roommate may have fallen back to sleep and forgotten. Resident R116 stated that the NA angrily said to roommate, 'I guess your roommate did it, because I heard about her.' Resident R116 said she sat up at the end of the bed to see who said that about her and told the NA she shouldn't talk that way. Resident R116 said the NA threw the curtain at her and hit her. The resident told the NA that she hit her with the curtain, and she was being rude. Resident R116 stated she got very upset and started shaking. The resident said she cried and wanted the NA to leave her room, but she wouldn't, so the resident left the room and screamed for help. Per the witness statement from Licensed Practical Nurse (LPN) Employee E 4, the nurse heard the resident screaming and went to see what was going on. Resident R116 told Employee E4 she did not like how the care nurse (E3) treated her and wanted her out of her room. Review of the witness statement from NA, E3 stated, She (Resident R116) wanted me out of her room, I ignored her and continued care. Review of the roommate's witness statement, facility deemed alert and oriented, Resident R159 stated The C.N.A. (NA E3) came in my room yelling and accusing me of turning on my call bell. My roommate, (Resident R116) told the NA she shouldn't be talking that way to me and they exchanged words. The NA whipped the curtain hitting my roommate. She (R116) was very upset, and I could hear it in her voice. She went yelling for help and people came to see what was going on. The aide was being disrespectful for no good reason. Everything my roommate reported is true. On January 27, 2025, the Director of Nursing reported an allegation of verbal abuse when Resident R116 alleged a NA called the resident a derogatory name. Review of the incident with Resident R116 on August 15, 2025, stated in the middle of the night she heard one of the residents calling out for help. The resident said she got up and saw an aide in the hallway sitting in a chair. The resident stated, I tried to explain to the aide that the resident needed help and hoped she would check on her. Instead, she told me to mind my own business and called me poor white trash. Resident R115 said she immediately went to the front desk and told the nurse. Review of the investigation revealed the DON conducted a telephone interview with the licensed practical nurse (LPN) Employee E5 who worked on the Resident R115's unit that night on the 11-7 shift. LPN told the DON that she heard commotion and went to see what was going on. It was documented in the LPN's witness statement that Resident R116 told the LPN twice that she (the NA) called her white trash. The same witness statement revealed the DON asked the LPN if this was reported to the supervisor. The LPN replied, 'No, she (the supervisor) defused the situation and corrected the C.N.A. regarding calling names or arguing with residents. The same investigation included a witness statement from a resident that stated he heard the lady across the hall yelling for help. Another</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews with resident and staff, review of clinical records, facility documentation and policy it was determined that the facility failed to complete a thorough investigation to rule out verbal and mental abuse for one resident during two incidents with staff of 39 resident records reviewed (Resident R116). Findings includeReview of the facility policy and procedures, revised on, October 2022 titled, Abuse of Residents states. It the facility's policy that acts of physical, verbal, psychological and financial abuse directed against residents are absolutely prohibited. The policy defines verbal abuse as to any use of oral written or gestured language that included disparaging and derogatory terms to residents and their families, or within hearing distance to describe residents, regardless of their age, ability to comprehend or disability. The same policy states, Mental abuse, includes, but not limited to resident humiliation intimidation threatening demeanor, harassment and threats of punishment or withholding a treatment, services, or privileges. The same policy further states that the Administrator/Director of Nursing/designee will conduct an investigation to include but not limited to interview any witnesses to the incident, the resident, staff members on all shifts having contact with the resident during the period of the alleged incident. The same policy states, The Administrator/Director of Nursing is responsible to receive and investigate all alleged violations timely, thoroughly, and objectively. Resident R116 was admitted to the facility on [DATE], with diagnosed with Multiple Sclerosis (an immune system eats away at the protective covering of nerves), Fibromyalgia (a chronic condition causing widespread musculoskeletal pain, and fatigue), bipolar (mood swings), and clinically documented alert, oriented and had the cognitive ability to make autonomous choices.Review of a facility reported event dated January 2, 2025, revealed an allegation of staff to resident verbal abusive behavior by a staff member, (NA), Employee E3 to Resident R116. Interview, on August 15, 2025, at 2:00 p.m. with the Director of Nursing (DON) confirmed the above to be true but thought the allegation was unsubstantiated because the perpetrator, Nurse Aide Employee E3 since resigned from working at the facility. On January 27, 2025, the Director of Nursing reported an allegation of verbal abuse when Resident R116 alleged a NA called the resident a derogatory name, [NAME] Trash. The DON concluded in the investigation that the facility was, Unable to substantiate the allegation of verbal abuse. No one else heard the encounter staff nor resident. The roommate and 3 other residents were interviewed and did not voice and care (sic) concerns nor did they hear the encounter and (The resident's name) is Being followed by psych.During an interview with the DON on August 15, 2025, at 2:00 p.m. the DON confirmed the DON knew the names of the perpetrator and the supervisor who disciplined the staff member but both witness statements were omitted from the investigation.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations of care and treatments, clinical record review, interviews with residents and staff, and reviews of policies and procedures, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan for each resident to meet the resident's medical, nursing and mental and psychosocial needs identified in the comprehensive assessment for two of 31 residents reviewed. (Resident R116 and R180). Findings include Review of the facility's policy titled, Care plan Policy revised March 2024, states the interdisciplinary team (IDT) is responsible for the development of resident care plans. Each resident's care plan is consistent with the resident's right to participate in the development and implementation of his or her plan of care including the right to participate in the planning process, request revisions, see the care plan and sign it after significant changes are made. The same policy states that care plan interventions are chosen based on relevant clinical data and decision making. Resident R116 was admitted to the facility on [DATE], with diagnoses of Multiple Sclerosis (an immune system eats away at the protective covering of nerves), Fibromyalgia (a chronic condition causing widespread musculoskeletal pain, and fatigue), bipolar (mood swings), and clinically documented alert, oriented and had the cognitive ability to make autonomous choices. Review of Resident R116 care plan dated January 3, 2025, revealed the resident had behavior problem related to making false allegations against staff. Review of Resident R116's nursing progress notes revealed January 4, 2025, the resident was noted without any moods or behaviors. Nurse Practitioner's note, dated, January 17, 2025, stated, The resident is calm, Bipolar diagnosis is stable and mild. Review of the January 24, 2025, activities note, noted Resident R116 More involved during group, and Comes to all group programs, enjoys socializing with the activity team and her neighbors, continues to participate in special events, helping others, socializing with peers/staff. Review of Resident R116 psychological progress note dated January 28, 2025, noted that the nurse manager told the clinician a staff member made an inappropriate comment towards the resident and was suspended. The clinician asked during the therapy session how Resident R116 was feeling after the incident. and Resident R116 stated, 'She was feeling better and expressed being concerned about another resident who was yelling and that the resident likes helping and supporting others.' It was also noted that the clinician praised her efforts and that She did nothing wrong. The Director of Nursing on August 15, 2025, at 4:00 p.m. was asked to show documentation and evidence of Resident R116 making false allegations against staff. The DON stated she was accused of making false allegations from her prior institution but failed to show evidence nor evidence this occurred at the facility. Furthermore, during an interview with Resident R116 on August 15, 2025, at 1:00 p.m. stated she was not told nor signed any revisions to her care plan related to making false allegations against staff and stated this was not true. A review of the facility policy titled care plans dated March 2024 revealed that the interdisciplinary team was responsible for the development of resident care plans. The team was responsible for developing, implementation and revision of a comprehensive person-center care plan that included measurable objectives and timetables to meet each resident's physical, psychosocial and functional needs. The policy also indicated that the person-centered care plan was based on the comprehensive assessment. The interdisciplinary care team includes the attending physician, licensed nursing staff, members of the food and nutrition services, the resident and/or resident's representative and other staff to meet the resident's needs. Clinical record review for Resident R180 revealed a comprehensive assessment (MDS-an assessment of care needs) dated April 29, 2025, revealed that this resident had difficulty communicating some words or finishing thoughts and that cueing was required to complete recall. The assessment also indicated that Resident R180 required partial/moderate assistance of a staff member with toileting (the ability to maintain perineal hygiene, adjust clothes before and after having a bowel movement. The assessment also indicated that Resident R180 required partial/ moderate assist of a staff member for sit to stand (the ability to come to a standing position from sitting in a chair wheelchair or side of bed). The assessment indicated that for chair to bed/bed to chair transfers Resident R180 required supervision or touching assist (the staff member provides verbal cues and/or touching steadying and/or contact guard assistance as resident completes the activity). The assessment said that Resident R180 was frequently incontinent of bowel. A diagnosis of non-Alzheimer's Dementia and difficulty walking was assessed for Resident R180. Clinical record review revealed a social worker's assessment and progress note for Resident R180 dated May 3, 2025, that indicated the resident was not cognitively intact scoring a</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical records review and staff interview, it was determined that the facility failed to ensure that a resident on oxygen therapy was assessed for the need of oxygen for one of 31 resident records reviewed. (Resident R127) Findings Include: Review of facility policy titled Oxygen Therapy dated February 10, 2010, revealed that under section Policy: It is the policy of the facility that oxygen therapy is administered per physician's order or as an emergency measure until a physician order is obtained. Under section Steps to administer oxygen # 12. Document the procedure in the medical record. Review of Resident R127 revealed that Resident R127 was admitted to the facility on [DATE], with a diagnosis of Peripheral Vascular Disease (poor circulations of the extremities). Review of physician's order revealed an order for Oxygen at 2 liters n/c (nasal cannula) PRN (when needed) every shift, notify MD if oxygen is less than 94% as needed for SOB (shortness of breath). Observation on initial tour of the unit conducted on August 11, 2025, revealed that Resident R127's was on oxygen concentrator via nasal cannula. Interview with Licensed nurse, Employee E13 confirmed that Resident R127 was on 2 liters of Oxygen. Observation conducted during wound care on August 13, 2025, at 10:00 AM revealed that resident was on oxygen via nasal cannula at 2 liters/minute via nasal cannula Follow-up observation conducted on August 15, 2025, at 12:02PM revealed that resident was on Oxygen at 2 liters/minute. Review of resident R127's clinical record revealed no documented evidence that Resident R127 was assessed for the need for Oxygen. 28 Pa Code 201.18 (b)(1) Management 28 Pa. Code 211.10 (c) Resident care policies 28 Pa. Code 211.12 (c)(d)(1)(3) Nursing services</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>Based upon interviews with staff, review of residents' records, and facility policy it was determined the facility failed to determine one resident with a substantial weight loss was reweighed in a timely manner for one of 39 resident records reviewed (Resident R99) Findings include Review of the facility's policy titled, Weight and Weight Change Management not dated states, Residents with a suspected weight change (per MDS guidelines) will have a reweigh completed in a timely manner. Review of Resident R99 weights reveal on July 17, 2025, a weight of 140.6 lbs. and on July 23, 2025, was 133.6 lbs. calculating a substantial weight loss per MDS guidelines, of 4.98% in six days. Further review of Resident R99 clinical record revealed the facility failed to re-weigh the resident in a timely manner. This was confirmed with the registered dietician on August 12, 2025, who confirmed the substantial change in weight loss should have been reweighed and was not done.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of clinical records and staff interview, it was determined that the facility failed to ensure that oxygen was administered in accordance with physician orders for one of one resident observed in oxygen therapy. (Resident R167) Findings Include: Review of facility policy entitled Oxygen Therapy dated February 10, 2010, revealed that under section Policy: It is the policy of the facility that oxygen therapy is administered per physician's order or as an emergency measure until a physician order is obtained. Review of Resident R167's clinical record revealed that resident was admitted to the facility on [DATE], with the diagnosis of Chronic Obstructed Pulmonary Disease (COPD). Review of physician's order dated July 4, 2025, revealed an order to administer Oxygen at 3L (liters)/min via nasal cannula continuously every shift. Review of MDS (minimum data set- a federally required resident assessment conducted at a specific interval) dated May 3, 2025, revealed that resident was on oxygen. Review of Resident R167's care plan revealed that resident has altered respiratory status/Difficulty Breathing related to COPD. Date Initiated: 01/08/2025. The intervention listed included to administer oxygen @ 2LNC (nasal cannula) to maintain SaO2 (saturated oxygen levels) at or above 92%. Observation on Resident R167 conducted on August 11, 2025, at 10:20AM revealed that resident was oxygen concentrator via nasal cannula at 2.5 liters/ minute. Interview with resident conducted at the time of observation revealed that he was on oxygen at 3 liters/minute. Further resident revealed that he gets short of breath sometimes. Interview with licensed nurse Employee E14 conducted at the time of the observation revealed that nurse read the oxygen concentrator flow meter standing up at 3 liters/ minute. Nurse rechecked the oxygen level at eye level and confirmed that oxygen reading was 2.5 liters. Employee E14 adjusted the level to 3 liters/minute. Interview with DON (Director of Nursing) Employee E2 conducted on August 13 at 2:05 PM revealed that oxygen gauge should be read at eye level. 28 Pa. Code 211.12(d)(5) Nursing services</p>

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>Based on interviews with staff, reviews of clinical records and policies and procedures, observations of resident care and treatment, it was determined that for one of 31 residents reviewed, the facility failed to administer and use its' resources effectively and efficiently to maintain the highest practicable physical, mental and psychosocial well-being of each resident. (Resident R180). Findings Include: A review of the facility's policy titled incident and accident dated July 2025, revealed the facility was responsible to complete a report of all accidents/incidents for each resident. The facility was responsible for investigation of the incident/accident for each resident to determine the risk factors that contributed to the event. The facility was also responsible to ensure that the resident's environment was free of accident hazards as possible. The policy said that the interdisciplinary team would develop a care plan to ensure that the resident's environment was free of accident hazards as possible. The policy indicated that the completed investigation and review by the director of nursing would be forwarded to the medical director and administrator. The policy said that the medical director shall be consulted about the conclusion of the incident/accident investigation as desired. Interview with the director of nursing Employee E2 and the administrator Employee E1 at 2:30 p.m., on August 13, 2025, confirmed that they were aware of the incident/accident that occurred on May 7, 2025, for R180; whereby the resident was found lying on the floor in the bedroom/adjoining bathroom. The administrative staff (Employees E1 and E2) confirmed that there was no care plan developed and implemented for bowel incontinence, individualized toileting schedule, toileting and staff supervision or touching assistance with all transfers for Resident R180. Interview with the medical director, Employee E12 at 11:00 a.m., on August 14, 2025, revealed that on May 7, 2025, Resident R180 was sent to the hospital emergency room for a brain bleed or ischemic stroke and fall. The physician also reported that the cause of the fall was determined in the emergency room on May 7, 2025, when Resident R180 was assessed and diagnosed with an acute large intraparenchymal hemorrhage (a type of stroke that occurs when blood from a ruptured blood vessel leaks into the brain tissue.) and hydrocephalus. The physician explained that this intraparenchymal hemorrhage was a progressive neurological disease that occurs when abnormal amyloid proteins build up in the brain's blood vessels causing them to leak. The physician also said that Resident R180 had a history of cerebral amyloid angiopathy and prior intracranial parenchymal hemorrhages in 2018. Interview with Employees R1 and R2 at 11:30 a.m., on August 14, 2025, confirmed that they did not conduct and record a complete and thorough investigation into the incident/accident that occurred on May 7, 2025, for Resident R180. The administrative staff failed to use its' resources effectively to identify the root cause of the fall on May 7, 2025, for Resident R180 by consulting with the medical director as stipulated in the facility's policy for investigation of incidents and accidents to ensure a safe environment for residents. 28 PA. Code 211.10(a)(b)(c)(d) Resident care policies28 PA. Code 211.12(d)(1)(2)(3)(5) Nursing services28 PA. Code 201.14(a) Responsibility of licensee28 PA. Code 201.18(b)(1)(3)(e)(1)(3) Management</p>		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical records review and staff interview, it was determined that the facility failed to ensure that residents clinical records were completed related to oxygen therapy for one of 31 resident records reviewed. (Resident R127) Findings Include: Review of facility policy titled Oxygen Therapy dated February 10, 2010, revealed that under section Policy: It is the policy of the facility that oxygen therapy is administered per physician's order or as an emergency measure until a physician order is obtained. Under section Steps to administer oxygen # 12. Document the procedure in the medical record. Review of Resident R127 revealed that Resident R127 was admitted to the facility on [DATE], with a diagnosis of Peripheral Vascular Disease (poor circulations of the extremities). Review of physician's order revealed an order for Oxygen at 2 liters n/c (nasal cannula) PRN (when needed) every shift, notify MD if oxygen is less than 94% as needed for SOB (shortness of breath). Observation on initial tour of the unit conducted on August 11, 2025, revealed that Resident R127's was on oxygen concentrator via nasal cannula. Interview with Licensed nurse, Employee E13 confirmed that Resident R127 was on 2 liters of Oxygen. Observation conducted during wound care on August 13, 2025, at 10:00 AM revealed that resident was on oxygen via nasal cannula at 2 liters/minute via nasal cannula Follow-up observation conducted on August 15, 2025, at 12:02PM revealed that resident was on Oxygen at 2 liters/minute. Review of August 2025 Treatment Administration Record revealed that there were no initials indicating that oxygen was administered to Resident R127 28 Pa Code 201.18 (b)(1) Management 28 Pa. Code 211.10 (c) Resident care policies 28 Pa. Code 211.12 (c)(d)(1)(3) Nursing services		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation and staff interview, it was determined that the facility failed to follow infection control procedures during medication administration to one of one resident observed during medication pass. (Resident R127) Findings Include: Review of an undated facility policy entitled Infection Control Policy revealed that under section Policy #1. The infection control nurse, in conjunction with the Quality Assurance committee, has responsibility for overall infection control in the building. Under section Purpose In order to provide maximum protection to residents, visitors, and personnel from pathogenic microorganisms and infectious diseases, methods of prevention and control shall be implemented. Medication administration observation conducted on August 12, 2025, at 10:56 AM revealed that the Licensed nurse, Employee E15 was in the process of administering medications to Resident R127. Further observation revealed that two white tablets were on top of the medication cart. Interview with Licensed nurse, Employee E15, conducted at the time of the observation revealed that the two tablets on top of the medication cart were two tablets of Gabapentin. Further, Employee E15 confirmed that that she placed the two tablets of Gabapentin on top of the medication cart because she was preparing to crush it before administering it to Resident R127 Further observation revealed that the nurse proceeded to crush the medication and proceeded to administer the crushed medication to Resident R127 via PEG tube (percutaneous endoscopic gastrostomy tube- a tube placed through the abdomen into the stomach used to provide nutrition and medications). 28 Pa. Code 201.14(a) Responsibility of licensee.</p>