

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395983	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2024
NAME OF PROVIDER OR SUPPLIER Kearsley Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 North 49th Street Philadelphia, PA 19131	

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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38735</p> <p>Based on a review of clinical records, review of facility policy and staff interviews, it was determined that the facility did not maintain complete and accurate clinical records related to enteral feeding volume documentation for 2 of 21 records reviewed (Resident R64 and Resident R191).</p> <p>Findings include:</p> <p>Review of the facility's policy, Charting and Documentation, with a revision date of July 2017 indicated that documentation in the resident's medical record will be objective, complete and accurate. Continued review of the policy indicated that documentation of procedures and treatment will include care specific details that include, but not limited to:</p> <p>Documentation of procedures and treatments will include care-specific details, including, but not limited to:</p> <ul style="list-style-type: none"> -the date and time the procedure/treatment was provided -how the resident tolerated the procedure/treatment -whether the resident refused the procedure/treatment -notification of family, physician or other staff, if indicated <p>Review of Resident R64's clinical record revealed the resident was admitted to the facility on [DATE], with diagnosis to include but not limited to dysphagia, oropharyngeal phase (difficulty transferring food from the mouth into the pharynx (part of the throat behind the mouth and nasal cavity) and esophagus (food tube connecting pharynx to stomach) to initiate the involuntary swallowing process).</p> <p>Further review of Resident R64's clinical record revealed physician orders dated June 29, 2024, enteral feed order four times a day one carton of Jevity 1.5 = 355 ml via PEG daily.</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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R64's medication administration record (MAR) revealed that most shifts it was documented that 355 ml's of formula were administered from July 1, 2024, to July 15, 2024, when the order was changed. The new enteral feeding order on July 15, 2024, was four times a day, five cartons of Jevity 1.5 via PEG daily.</p> <p>Further review of Resident R64's MAR revealed that on July 17, 2024, all four feeding were documented as 770 ml.</p> <p>Interview with Employee E11, LPN, on July 18, 2024, at 10:50 a.m. revealed that one carton of Jevity 1.5 was 237 ml, or roughly 240 ml, and not 355 ml as was charted from July 1, 2024, through July 15, 2024. Observation of a carton of Jevity 1.5 provided by Employee E11, revealed that the carton was 237 ml, and contained 355 calories. Employee E11 indicated that the order which stated one carton provided 355 ml was not accurate, and that staff, including her, should have documented 237 or 240 ml for each feeding that was one carton.</p> <p>Interview with the Director of Nursing on July 18, 2024, at 11:15 a.m. confirmed that the June 29, 2024, enteral feeding order had the wrong volume for a carton of Jevity 1.5 which was 240 ml, not 355 ml, and that most of the volumes listed on the July MAR for Resident R64 were not documented accurately.</p> <p>Interview with Employee E12, Registered Dietitian on July 19, 2024 at 10:55 a.m., revealed that she had documented in a June 25, 2024, nutrition progress note in Resident R64's record that a carton of Jevity was 355 ml, which was the caloric value and not the volume. She indicated that the error on her June 25, 2024, recommendation may have caused the error on the June 29, 2024, enteral feeding order.</p> <p>Review of the February 2024 physician orders for Resident R191 included the following diagnosis: atrial fibrillation (irregular and often very rapid heartbeat); hypertension (high blood pressure), and heart failure (a condition in which the heart cannot pump blood as well as it should causing an individual to have fluid buildup and shortness of breath).</p> <p>Resident R191 was admitted into the facility on [DATE], and discharged home on February 20,2024 with his daughter.</p> <p>During an interview with Resident R191 on July 15, 2024, at 2:20 p.m. reported that the cardiologist who visit him at the facility changed his dosage of his Lasix (a diuretic that treats fluid retention and high blood pressure) shortly after he arrived at the facility for care in October 2024, and did not tell him about this.</p> <p>Review of a note from the Cardiologist on October 20, 2023, at 12:38 p.m. indicated that the resident was seen by the cardiologist on the referenced date and that the dosage of his Lasix was decreased to from 60 milligrams a day to 40 milligrams a day. Review of the note did not show evidence that the resident was notified of the change in the dosage of the Lasix that the cardiologist was recommending.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Director of Nursing (DON) on June 22, 2024 at 11:00 a.m. the DON reported that she accompanies the cardiologist around the facility when he meets with residents and notifies them verbally of any changes that he will make regarding their care. During the above referenced interview, the DON acknowledged that there was no documentation during the October 20, 2024 visit indicating that the resident was notified about the recommended changes from the cardiologist.</p> <p>28 Pa Code: 211.5(f) Clinical records.</p> <p>28 Pa Code: 211.12(d)(1)(5) Nursing services.</p>		