STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395983	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kearsley Rehabilitation and Nursing Center	2100 North 49th Street Philadelphia, PA 19131

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277 Based on review of facility documentation, review of clinical records, and staff interview it was determined that the facility failed to develop and implement a baseline care plan related to a pressure ulcer for one of two new admissions reviewed (Resident R47). Findings Include: Review of facility policy Care Plans - Baseline revealed a baseline plan of care to meet the resident's immediate health/safety needs is developed for each resident within 48 hours of admission. Review of Resident R47's admission Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated April 10, 2025, revealed the resident was admitted to the facility on [DATE], and had diagnoses of muscle weakness, malnutrition (deficiencies, excesses, or imbalances in a person's intake of energy and/or nutrients), and depression (mood disorder which causes persistent feelings of sadness of loss of interest). Continued review of the MDS dated [DATE], included a review of Section M - Skin Conditions which indicated Resident R47 was at risk of developing pressure ulcers/injuries and had an unhealed pressure ulcer/injury. Resident R47 was noted to have an unstageable deep tissue injury. Review of facility wound report dated April 7, 2025, revealed Resident R47 had a left medial heel deep tissue injury that was present at the time of admission on April 4, 2025. Review of Resident R47's clinical record and baseline care plan revealed no documented evidence a baseline care plan was created to include the interventions and treatments for the left heel deep tissue injury that was present at the time of admission. Review of Resident R47's clinical record revealed a care plan for the left heel deep tissue injury was not developed and implemented until April 8, 2025. 28 Pa. Code 211.10 (d) Resident care policies.

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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52389 Based on observations and clinical record review, it was determined that the facility did not ensure the comprehensive care plan was implemented related to communication for one of 18 residents reviewed (Resident R46). Finding include: Review of Resident R46 's clinical record revealed that Resident R46 was admitted to the facility on [DATE] with diagnoses of, but not limited to, Chronic Respiratory Failure, Cerebrovascular Accident (also known as a stroke), cognitive impairment. Review of Resident R46's care plan revised on October 1, 2024 revealed that Resident R46 has a communication deficit related to Aphasia. Intervention implemented on December 12, 2022 that Resident R46 is able to communicate by: lip reading, writing, communication board, gestures, sign language, translator. Further review of Resident R46's care plan revised on February 1, 2021 revealed that Resident R46 is dependent on staff for activities, cognitive stimulation, social interaction related to immobility, physical limitations. Interventions implemented on February 1, 2021 for all staff to converse with resident while providing care. Observation on May 13, 2025 at 11:45am revealed Licensed Practical Nurse, Employee E3, providing care to Resident R46. Resident R46 appearing agitated and confused, stating I'm scared. Employee E3 preformed care without speaking or addressing the resident, no reassurance or directions provided to the resident.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44882 Based on review of clinical documentation and staff interviews, it was determined the facility failed to ensure adequate supervision during care by ensuring two staff were available for one of two residents reviewed (Resident R56). This failure resulted in actual harm to Resident R56 who fell out of bed and sustained a compound fracture of the right femur (hip). This deficiency was identified as past non-compliance. Findings include: Review of Resident R56's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses of cerebral infarction (area of brain tissue that has died), psychomotor deficit (slowing down of both thoughts and physical movements) following cerebral infarction, Hemiplegia and Hemiparesis (paralysis affecting only one side of the body) affecting the right dominant side, and need for assistance with personal care. Review of Resident R56's quarterly MDS (Minimum Data Set, periodic assessment of resident care needs), section G, Functional Status, dated [DATE], revealed the resident required extensive assistance of two or more staff members for bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture). Further review of of Resident R56's MDS assessment, Section C, Cognitive Patterns, revealed the resident was rarely understood, and a Staff Assessment for Mental Status concluded the resident had long and short term memory deficits and was unable to recall the current season, location of his/her room, names and faces of staff members, or that he/she was a resident in a nursing facility. As such, it was determined the resident was non-interviewable. Review of Resident R56's care plan dated February 12, 2025 revealed the following intervention, I am dependent on 2 staff and a sheet for turning and repositioning. Review of Resident R56's bedside Kardex report (report of information available to nurse aides to alert them to resident care needs) revealed an intervention under the section Bed Mobility/Positioning which indicated I am dependent on 2 staff and a sheet for turning and repositioning. Review of the nursing notes for Resident R56 revealed a note written by Registered Nurse Supervisor, Employee E6, on [DATE], at 6:17 a.m. The nursing note indicated, Called by nurse to assess resident . related to fall. Resident was lying on floor to left side of [his/her] bed. Resident was noted bleeding from left knee from tiny laceration Resident transported to ER (emergency room) at 6:23 am. Continued review of nursing notes revealed a note from Licensed Nurse, Employee E7, on [DATE], at 8:19 a. m. which revealed, @ 6am I heard a scream, then heard CNA (nurse aide) calling for me, I immediately ran to the room, observing the resident in a sitting position with right knee pulsating with blood, from a small laceration, large amount of blood observed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of facility's incident report for Resident R56 revealed a fall occurred on [DATE], at 6:00 a.m. The report indicated the fall was witnessed, and the resident lowered himself/herself to the ground. The report concluded the resident slid from bed while receiving incontinent care. [Resident R56] is dependent on toileting, was being toileted as usual with [his/her] routine CNA (Nurse Aide, Employee E8). [The resident], while holding onto [his/her]right assist rail, [his/her] legs slid off the bed onto the floor .[she/he] held onto the rail, preventing [his/her] top half from falling, the CNA safely lowered [him/her] to the floor. The report further revealed the resident was sent to the emergency department for evaluation. [Resident R56] was admitted to the hospital with a diagnosis of fractured femur (hip), and that he/she underwent surgical fracture repair. Review of the hospital documentation signed by hospital physician, Employee E9, revealed Resident R56 had been admitted to the hospital with an open fracture (where the bone protrudes through the skin) of the right femur, which will require operative fixation. Telephone interview with Employees E6, E7, and E8 were conducted on [DATE]. Interview with RN Supervisor, Employee E6 at 2:38 p.m. revealed on the night of the fall, he was summoned to the room to assess the resident following the incident. He stated that staff was providing care to Resident R56 when he/she fell out of bed, and that upon his entry to the room, the only staff present were the charge nurse, Employee E7, and the nurse aide, Employee E8. Interview with the charge nurse, Employee E7, at [DATE] at 2:44 p.m., revealed, I was outside [the room] and I heard a scream and the CNA (Employee E8) calling for help. I went in and saw the CNA holding the resident up. [He/she] was [rolled] on [his/her] right side, which is [his/her] weak side . [Employee E8] said she had turned [resident], and [he/she] slipped off the bed. The bed was high because it was in position for the CNA. She further stated that this was the first fall for the resident in the three years [he/she]'s been here, and the Nurse aide, Employee E8 was the only staff member present in the room at the time of the fall. She also stated the resident was not on paired care. Charge nurse, Employee E7 had been unaware at the time of the resident's needed level of assistance for bed mobility and turning was a two or more person assist. Interview with the Nurse Aide, Employee E8, on [DATE] at 2:48 p.m., revealed during continence care, I was changing [resident], and [he/she] was on [his/her] side. I don't even really know how [resident's] legs slipped off the bed .it was just me. I rolled [him/her] side to side . I was changing [resident], and [his/her] legs slipped off. Employee E8 revealed the resident had been rolled to the right side of the bed, holding the rail with [his/her] left arm. Employee E8 clarified that she had been standing on the left side of the bed at the time, and that the resident's legs had slid out of the right side of the bed, opposite of where she was standing. She said that she was able to assist the resident to the floor, and then called the charge nurse for help. She revealed that she was not aware at the time of the incident, the resident required assistance of two or more staff for bed mobility and repositioning. On [DATE], the Nursing Home Administrator (NHA), Employee E1, presented documentation indicating that the facility had initiated a plan of correction on [DATE], related to ensuring nursing staff were made aware of the level of assistance required for care of residents and they verified ADL (Activities of Daily Living) care needs including bed mobility and transfer status prior to providing care. Review of facility Action plan/Follow up documentation revealed the following information. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1. [Resident R56] care plan and Kardex have been updated to reflect current needs. 2. Sweep of current residents conducted to ensure ADL care needs reflect their current needs and are reflective in the care plan and Kardex. 3. Contracted Occupational Therapist educated on ensuring changes in care needs are reflective in the care plan and communicated to the resident's charge nurse. Also, it is vital to ensure current care needs are resolved or edited when a change is made [to] any previous bed mobility. 4. NHA or designee will conduct weekly audits to ensure care plan and Kardex clearly indicate the level of care needed. Results of the audits will be reviewed by the QAA (Quality Assurance) committee and the QAA committee will determine continuation of audits. The facility alleged a date of compliance with this plan of correction of [DATE]. Facility education record and subsequent audits were verified for completion. Staff were interviewed to verify education of facility policy on assistance level verification for ADL care. Nursing staff and resident interviews were conducted to verify compliance with the plan of correction. No continuing concerns were identified through record review, interview or observation. This deficiency was cited as past non-compliance. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52389 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that weights were monitored for two of 18 residents reviewed (Resident R23, R29) Findings include Review of Resident R23 's clinical record revealed that Resident R23 was admitted to the facility on [DATE] with diagnoses of, but not limited to, fracture of thoracic vertebrae (middle of back) , Type 2 diabetes, malnutrition. Review of Resident R23's care plan revised on December 9, 2024, revealed that resident has a nutritional problem or potential nutritional problem related to past medical history, underweight, fat/ muscle loss, skin breakdown/wounds. Intervention implemented on December 9, 2024 to obtain weights as ordered. Review of Resident R23's physician orders revealed an order dated December 4, 2024 for weights monthly. Review of Resident 23's clinical record revealed on March 4, 2025 Resident R23 weighed 105.4 and April 9, 2025 Resident R23 weighed 102.8 lbs (-2.47%). Further review of clinical record revealed on May 1, 2025, Resident R23 weighed 96.0 lbs (-6.61%). Further review of Resident 23 's clinical record revealed no documented evidence of reweigh or nutritional assessment related to significant weight change. Review of Resident R29 's clinical record revealed that Resident R29 was admitted to the facility on [DATE] with diagnoses of, but not limited to, osteoarthritis, hyperlipidemia, type 2 diabetes. Review of Resident R29's care plan revised on March 13, 2025 revealed that resident has a nutritional problem or potential nutritional problem related to past medical history, bedbound, therapeutic diet, altered diet texture, obesity, difficulty swallowing, abnormal labs, wound. Intervention implemented on March 13, 2025 for Registered Dietician to evaluate nutritional status and make recommendations as applicable as needed. Review of Resident R29's clinical record revealed on April 16, 2025 Resident R29 weighed 219.lbs. Further review of clinical record revealed on May 6, 2025, Resident R29 weighed 203.6 lbs (-7.6%). Further review of Resident 29 's clinical record revealed no documented evidence of reweigh or nutritional assessment related to significant weight change. 28 Pa. Code 211.12(c) Resident care policies 28 Pa. Code: 211.12(c)(d)(1) Nursing services

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 52389 Based on observations, review of facility policies, clinical record review and interviews with staff, it was determined that the facility failed to ensure that the medication error rate was less than five percent for one of three residents observed during medication administration (Residents R6). Findings include: The facility's medication error rate was 40% based on observation of 25 medication administration opportunities with 10 errors observed. Review of facility policy, Administering Medications revised April 2019, revealed, Medications are administered withing one hour of their prescribed time, unless otherwise specified. Review of Medication Administration Records (MARs) for Resident R6 revealed the following physician's orders: Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3ML) 0.083% 1 inhalation inhale orally via nebulizer four times a day, administration time ordered for May 13, 2025, at 9:00am. Amlodipine Besylate Oral Tablet 10 MG Give 1 tablet by mouth one time a day related to hypertension, administration time ordered for May 13, 2025, at 9:00am. Azithromycin Oral Tablet 250 MG Give 1 tablet by mouth one time a day for bacterial infection, administration time ordered for May 13, 2025, at 9:00am. Aspirin EC Tablet Delayed Release 81 MG Give 1 tablet by mouth one time a day for prophylaxis, administration time ordered for May 13, 2025, at 9:00am. Cholecalciferol Oral Capsule 50 MCG Give 1 capsule by mouth one time a day for supplement, administration time ordered for May 13, 2025, at 9:00am. Budesonide Inhalation Suspension 0.5 MG/2ML 2 ml inhale orally two times a day for Wheezing/Shortness of breath, administration time ordered for May 13, 2025, at 9:00am. Escitalopram Oxalate Oral Tablet 10 MG Give 1 tablet by mouth one time a day related To Generalized anxiety disorder, administration time ordered for May 13, 2025, at 9:00am. Fenofibrate Oral Tablet 160 MG Give 1 tablet by mouth one time a day related to Hyperlipidemia, administration time ordered for May 13, 2025, at 9:00am. Gabapentin Oral Tablet 600 MG Give 1 tablet by mouth three times a day for Nerve pain, administration time ordered for May 13, 2025, at 9:00am. Prednisone Tablet Give 10 mg by mouth one time a day related to age-related osteoporosis without current pathological fracture, administration time ordered for May 13, 2025, at 9:00am. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of morning medication pass on May 13, 2025, at 12:00pm revealed that Licensed Practical Nurse, Employee E3, verified physician orders for Resident R6's medications. Interview with Licensed Practical Nurse, Employee E3 confirmed that all medications that will be given were ordered for 09:00am. Observation of all above listed medications being administered to Resident R6 on May 13, 2025, at 12:05pm. Interview with Administrator, Employee E1 on May 13, 2025, at 2:00pm confirmed that medications were being passed late because of staffing issues. Further review of Resident R6's clinical record revealed no documented evidence that physician was notified prior to administering medications related to late administration of medications. 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12 (d)(5) Nursing services

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52389 Based on observations, review of facility policies, clinical record review and interviews with staff, it was determined that the facility failed to be free of significant medication error for one of three residents (Residents R6). Findings include: Review of facility policy, Administering Medications revised April 2019, revealed, Medications are administered withing one hour of their prescribed time, unless otherwise specified. Review of Resident R6's clinical record revealed Resident R6 was admitted on [DATE] with diagnosis of, but not limited to COPD (Chronic Obstructive Pulmonary Disease), Diabetes, Hypertension (high blood pressure). Review of Resident R6' s MDS (Minimum Data Set) dated April 9, 2025, revealed that resident has a BIMS (Brief interview for mental status) of 15, indicating resident is cognitively intact. Review of Resident R6's physician orders revealed order for Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3ML) 0.083% 1 inhalation inhale orally via nebulizer four times a day, administration time ordered for May 13, 2025, at 9:00am. Further review revealed physician order for Budesonide Inhalation Suspension 0.5 MG/2ML 2 ml inhale orally two times a day for Wheezing/Shortness of breath, administration time ordered for May 13, 2025, at 9:00am. Interview with Resident R6 on May 13, 2025 at 11:30am revealed that resident had not received her morning medications on May 13, 2025 and she was most concerned with her breathing treatments because they help me breathe better, I really need them on time. Observation of Medication Pass on May 13, 2025 at 12:05 p.m. revealed Licensed Practical Nurse, Employee E3 administering Albuterol and Budesonide. Interview with Licensed Practical Nurse, Employee E3 confirmed medications being administered are ordered for May 13, 2025 at 09:00am. Further review of Resident R6's clinical record revealed no documented evidence that physician was notified prior to administering medications related to late administration of medications causing significant medication errors. Review of Medication Administration Records (MARs) for Resident R6, further revealed incorrect documentation for administration times for ten of ten medications passed during observation of medication pass on May 13, 2025, at 12:05pm. Per documentation entered by Licensed Practical Nurse, Employee E3, all medications were administered to Resident R6 on May 13, 2025 between 10:24am and 10:30am. Interview with Licensed Practical Nurse, Employee E3 on May 14, 2025, at 11:45am revealed that medications were not properly signed out at time of administration, I write it all down on paper and go back to document later. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(3) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 52389 Based observations and staff interviews, it was determined that facility did not ensure that opened medications were properly labeled with the date that the medication was opened for two of three medication carts reviewed and one of one medication room reviewed. (Upper Level Med room, Lower Level South Med Cart, Lower Level North Med Cart). Findings include: Observation of Medication cart on Lower-Level South Med Cart on May 14, 2025 at 10:05 a.m. revealed one opened bottle of medication, including Geri-tussin 200ml/10ml Solution, not labeled with an open date. Interview with Licensed nurse, Employee E4 on May 14, 2025 at 10:05am confirmed one opened bottles of medication not labeled with an open date. Observation of Medication cart on Lower-Level North Med Cart on May 13, 2025 at 11:45 am revealed two open packages, Albuterol Sulfate 0.083% nebulizer treatment and Budosemide 0.5mg/2ml nebulizer treatment, not labeled with an open date. Interview with Licensed nurse, Employee E3 on May 13, 2025 at 11:45am confirmed two opened packages of medication not labeled with an open date. Observation in Upper Level Med Room on May 14, 2025 at 11:12am revealed two open bottles including Vancomycin 50mg/ml oral solution and Tuberculin 5tu-0.1ml injectable, not labeled with open date. Interview with Employee E5 on May 14, 2025 at 11:12 a.m. confirmed two open bottles with no open date. 28 Pa. Code 211.12 (d)(1) Nursing services.