

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396002	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER Transitional Care Unit at Nazareth Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 2601 Holme Avenue Philadelphia, PA 19152	

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 0578</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 request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508</p> <p>Based on review of clinical record, review of facility policy and interviews with staff, it was determined that the facility failed to ensure that advanced directives/code status were in place for two of 11 clinical records reviewed (Resident R110 and Resident R111).</p> <p>Findings include:</p> <p>Review of facility policy on Advance Directive and Healthcare Agents and Representatives revealed that under section Purpose: The purpose of this policy is to ensure that [NAME] Hospital physicians and colleagues respect the health care decisions of its patients and comply with the requirement of Pennsylvania law governing Living Wills. Under section Policy: [NAME] Hospital will comply with the Living Will of a patient. Under section Admission Procedure: Upon admission to [NAME] Hospital facility, the patient shall be informed of the right to execute an Advance Health Care Directives. The patient access representative will ask the patient if the patient has executed a living will/advance health care directive and if the patient has designated someone to be the patient's health care agent. The response will be a mandatory field within the electronic medical record. (EMR). If a patient has a living will/advance health care directives, a copy will be requested and scanned directly into the EMR.</p> <p>Review of Resident R110's clinical record revealed that Resident R110 was admitted to the facility on [DATE].</p> <p>Further review of Resident R110's clinical record revealed that there was no advance directive in place and there no code status indicated Resident R110's clinical record. Review of Resident R110's physician orders revealed no order for advance directives or code status.</p> <p>Further review of Resident R110's clinical record revealed no documented evidence that advance directives was discussed with the resident.</p> <p>Interview with Resident R110 conducted on [DATE], at 2:52 p.m. with her sister acting as sign language interpreter revealed that she has a living will and wants one of the measures to be Do Not Resuscitate.</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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Social Worker Employee E3 conducted on [DATE], at 3:05 p.m. revealed that she was aware of Resident R110's Advance Directives. Further Employee E3 also revealed that she was waiting for the physician to order the resident's advance directives and that only the physician can order the advance directives, and that code status will not reflect in Resident R110's clinical record until the physician orders it.</p> <p>Interview with the DON (Director of Nursing) Employee E2 conducted on [DATE], at 3:10 p.m. confirmed that there was no advance directive in place in Resident R110's clinical record. Further DON Employee E2 also confirmed that the physician has not ordered the advanced directive and that until the physician enters the order for Resident R110's Advance Directives, it will not be reflected in Resident R110's clinical record.</p> <p>Further interview with DON Employee E2 revealed that without the advance directive or without the code status indicated in the resident's clinical record, the resident will be considered a full code.</p> <p>Review of Resident R111's clinical record revealed that Resident R111 was admitted to the facility on [DATE].</p> <p>Review of Resident R111's physician's orders revealed that a No CPR (Cardiopulmonary Resuscitation) and Do Not Intubate was ordered on [DATE], nine days after Resident R111's admission to the facility.</p> <p>Further review of Resident R111's clinical record revealed no documented evidence that advance directives was discussed with the resident from admission until [DATE].</p> <p>Interview with the DON (Director of Nursing) Employee E2 conducted on [DATE], at 03:10 PM confirmed that there was no advance directive in place in Resident R111's clinical record until [DATE], nine days after Resident R111 was admitted to the facility. Further DON Employee E2 also confirmed that there was no code status indicated in Resident R111's clinical record until the physician entered the order for No CPR (Cardiopulmonary Resuscitation) and Do Not Intubate on [DATE].</p> <p>Further interview with DON Employee E2 revealed that without the advance directive or without the code status indicated in the resident's clinical record, the resident will be considered a full code.</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 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>38947</p> <p>Based on staff interviews and the review of clinical records, it was determined that the facility failed to clarify a physician's order related to daily weights for one out of 11 residents reviewed (Resident R61).</p> <p>Findings include:</p> <p>Review of the facility policy, Weights, with a review date of August 2019 indicted that the purpose of the policy is to monitor weight gain or loss. The policy also indicated that nursing will notify the physician or any weight gain of 2 or more pounds in one day, and the dietician of any weight loss.</p> <p>Review of the guidelines that the facility follows for the management of heart failure, 22 AHA/ACC/HFSA Guideline for the Management of Heart Failure indicated that the facility's disease management programs may compromise education, self-management, medication optimization, device management, weight monitoring, exercise and dietary advices .</p> <p>Review of Resident R61's nursing note dated March 13, 2025 at 11:54 a.m. indicated that the resident was admitted in to the facility with diagnosis that included the following: Hypoxia (low levels of oxygen), and Congestive Heart Failure (excessive body/lung fluid caused by a weakened heart muscle).</p> <p>Review of the resident's March 2025 physician orders included a physician's order for the resident to have daily weights.</p> <p>Review of the resident's weights obtained by the facility included the following weights:</p> <p>March 13, 2025 -177lbs at 6:31 p.m.</p> <p>March 14, 2025 -180lbs at 6:10 a.m.</p> <p>March 14, 2025 -180lbs at 2:53 p.m.</p> <p>March 15, 2025 -183lbs at 6:00 a.m.</p> <p>March 16, 2025 -184lbs at 6:00 a.m.</p> <p>March 16 2025 -185lbs at 11:00 a.m.</p> <p>March 17, 2025 -185lbs 5:35 a.m.</p> <p>March 18, 2025 -185lbs at 5:37 a.m.</p> <p>March 19, 2025 -187lbs at 6:25 a.m.</p> <p>(continued on next page)</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>March 20, 2025 -188lbs at 6:00 a.m.</p> <p>During an interview with the Director of Nursing (DON) on March 20, 2025 at 12:30 p.m. the DON reported that the rationale behind the physician's order for daily weights was related to his diagnosis of CHF.</p> <p>The American Heart Association's article, Managing Heart Failure Symptoms, indicated that many people are first alerted to worsening heart failure when they notice a weight gain of more than two or three pounds in a 24-hour period or more than five pounds in a week. This weight gain may be due to retaining fluids since the heart is not functioning properly. It's a good idea to track your weight and check in with your health care professional if you notice sudden changes and to make sure that you know the amount of weight gain your health care professional considers to be a problem for you.</p> <p>Review of the resident's daily weights indicated that from March 13, 2025 through March 14, 2025 Resident R61 gained 3lbs.</p> <p>Review of the resident's daily weights indicated that from March 14, 2025 through March 15, 2025 Resident R61 gained an additional 3lbs.</p> <p>Review of the resident's daily weights indicated that from March 15, 2025 through March 16, 2025 Resident R61 gained an additional 1-2lbs</p> <p>Review of the resident's daily weights indicated that from March 16, 2025 through March 20, 2025, the resident gained an addition 4 lbs.</p> <p>Continued review of the resident's daily weight scheduled indicated that from the date of the resident's admission (March 13, 2025) through March 20, 2025, Resident R61 gained a total of 11lbs in an 8 day period.</p> <p>Review of the physician's order did not indicate when staff should alert the physician to weight gain.</p> <p>Continued review of the resident's physician notes did not show evidence that the resident's attending physician, was notified by nursing staff of the resident's initial weight gain, and any other weight gain thereafter.</p> <p>During an interview with the Director of Nursing (DON) on March 20, 2025 at 1:15 p.m. the DON reported that that all resident weights are discussed in morning meeting, but could not provide any evidence that the facility notified the physician of the resident's weight gain totaling 11 pounds within an 8 day period.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1) Nusing 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** 46508</p> <p>Based on observation, interviews with resident and staff, review of clinical records and facility policy, it was determined that the facility failed to maintain a peripheral inserted central catheter (PICC) consistent with professional standards of practice for one of one resident with a PICC line. (Resident R4)</p> <p>Findings include:</p> <p>Review of facility policy on Maintenance of Central Venous Catheters (CVC) revealed that under section Purpose: intravenous therapy for the administration of blood products, fluids, and parenteral nutrition, as well as for hemodynamic monitoring is an essential part of medical practice. The following policy pertains to all central venous catheters (CVC) utilized at [NAME] Health Mid-Atlantic region, including PICC. Under section Maintenance of the Catheter Site, # C. The insertion site will be evaluated every shift for evidence of complications. Assessments include gentle palpation of the site through the intact dressing to discern tenderness and visual inspection of insertion site through the transparent dressing.</p> <p>Observation conducted on March 17, 2025, at 10:35a.m. during the tour of the unit revealed that Resident R4 was in bed awake. Further an intravenous (IV) line was observed on the inner side of Resident R4's left upper arm.</p> <p>Interview with Resident R4 conducted at the time of the observation revealed that he gets antibiotics and that the nurses give him the antibiotic using the intravenous line on his left arm.</p> <p>Review of Resident R4's clinical record revealed that Resident R4 was admitted to the facility on [DATE].</p> <p>Further review of Resident R4's clinical record revealed an order dated March 7, 2025, for Ceftriaxone (Rocephine) IV syringe 2 gm IV 400 ml/hr. every 12 hours.</p> <p>Interview with DON (Director of Nursing) Employee E2 conducted on March 18, 2025, at 12:56 p.m. revealed that the facility follows the policy for central venous catheters in caring for all PICC (peripherally inserted central catheter-a thin flexible tube inserted into a vein in the upper arm and threaded into a large vein in the chest, near the heart. It is used to provide access for administering medications, fluids and nutrition.). Further DON Employee E2 also revealed that PICC lines are measured by the nurse who administers the antibiotic to ensure proper placement.</p> <p>Review of Resident R4's clinical record revealed that there was no documented evidence that Resident R4's PICC line site was evaluated every shift or on a regular basis and there was no documented evidence that the PICC line length was measured at any time from Resident R7's admission on March 7, 2025, up to March 17, 2025, to ascertain proper placement of the PICC line.</p> <p>Interview with DON Employee E2 confirmed that Resident R4's PICC line was not measured during his stay at the facility. Further DON Employee E2 revealed that PICC line length should be measured before administering an IV ABT (intra-venous antibiotic therapy) via PICC line.</p> <p>(continued on next page)</p>		

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508</p> <p>Based on observation, review of facility policy and procedure, it was determined that the facility failed to maintain an effective infection control program related to the hand hygiene during medication administration, and wound treatment for two of two residents observed. (Resident R61 and Resident R108)</p> <p>Findings include:</p> <p>Review of facility policy on medication administration revealed that the policy did not address hand washing and other infection control subjects. Review of facility policy on Hand Hygiene revealed that under section Purpose: To assure proper hand hygiene practices are utilized by employees during all activities including patient care, and to prevent transmission of infectious pathogens. Hand hygiene helps to physically remove infectious from hands. Hands can also be decontaminated using waterless alcohol hand sanitizer. Under section Policy: It is the policy of [NAME] Hospital to decrease the risk for transmission of nosocomial pathogens that may be carried on the hands of healthcare workers. Under section Procedure: #3 Hand hygiene will be performed at the following times and as necessary: #a. Before and after entering a patient's room #b. Before and after direct patient contact. #c. Before donning gloves. #d. After removing gloves.#g. after contact with objects (including equipment) located in a patient's environment.</p> <p>Medication administration observation conducted on March 19, 2025, at 8:50 a.m. with Licensed nurse Employee E4 revealed that during medication administration for Resident R61, Employee E4 was observed wearing gloves.</p> <p>Further observation revealed that Employee E4 proceeded to administer Resident R108's oral medications with the gloves on.</p> <p>Further observation revealed that Employee E4 was touching Resident R61's bed side table with the same gloves and proceeded to administer Resident R61 with an eye ointment without changing gloves.</p> <p>Medication administration observation conducted on March 19, 2025, at 9:38 a.m. with licensed nurse Employee E5 revealed that during medication administration for Resident R108, Employee E5 was observed wearing gloves</p> <p>Further observation revealed that Employee E5 proceeded to administer Resident R108's oral medications with the gloves on. Further, Employee E5 proceeded to apply Resident R108's Nystatin powder 100,00 units to Resident R108's groin without changing gloves.</p> <p>After applying the Nystatin powder 100,00 units to Resident R108's groin, Employee E5 proceeded to pull Resident R108's pajamas up, touched the bed, adjusted the bed controls, touched the overhead table, removed resident R108's heel booties, touched the bed controls to adjust the height of the bed and to elevate the head of bed without changing gloves or washing hands.</p> <p>28 Pa Code 211.12 (d)(1)(5) Nursing services</p>		