

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396070	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2025
NAME OF PROVIDER OR SUPPLIER The Pines at Philadelphia Rehab and Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 8410 Roosevelt Blvd 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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility investigations and grievance logs, it was determined that the facility failed to report allegation for neglect and misappropriation for two of 18 residents reviewed (Resident R19 and R51).Finding include:</p> <p>Review of facility policy titled Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property dated September of 2024 revealed that Misappropriation of resident property is defined as means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the residents consent. Further review revealed that Neglect is defined as the failure of the facility, its employees or services providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.</p> <p>It is a policy of this facility that abuse allegations including abuse, neglect, exploitation, or mistreatment including injuries of an unknown source and misappropriation of resident property are reported per federal and state law, in addition local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility. If an incident or allegation is considered reportable the administrator or designee will make an initial report to the state agency. Follow up investigation will be submitted to the state agency within five working days</p> <p>Review of facility grievances logs dated June 30, 2025, revealed that resident R 19 stated that money was taken from his nightstand, he noticed that cash was missing but didn't know exactly when the money was taken.</p> <p>Review of the facility documented valuable agreement dated May 23, 2025, revealed that the resident has \$6.00 in a wallet and wished to keep the money with him.</p> <p>Review of facility interview with resident R 19 stated that he noticed that the money was missing on June 30, 2025. Resident R19 confirmed he was aware that the drawer has a lock, he was not sure if he locked it.</p> <p>Review of the facility investigation included a review of facility security recorded taped footage of resident R19's hallway at time of suspected theft, and interviews with all staff that had access to the resident's room and five residents residing on the same nursing unit.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with NHA employee E1 on July 16, 2025 at 12:58 PM confirmed that the incident was thoroughly investigated and a perpetrator was identified and terminated. Employee E1 confirmed that the incident was not reported.</p> <p>28 Pa. Code 201.14(a) responsibility of Licensee</p> <p>No Notes</p> <p>Review of facility grievance log revealed grievance report for Resident R51, dated June 12, 2025, reporting that "Resident reported to SSD that on June 12, 2025 during first shift 2 girls (Black girl with [NAME] Mouse shirt and Spanish girl) were changing her diaper. While changing her diaper the black girl said, "Don't pull that." Then the Spanish girl yanked out her biliary drain (a thin, flexible tube that is used to drain bile). Resident stated that she then had to go to the hospital and while at the hospital they had to recut her to put another biliary drain in."</p> <p>Review of Resident R51's clinical record revealed that resident was admitted to facility on April 20, 2025, with diagnosis of, but not limited to, Acute Cholecystitis (inflammation of the gallbladder that occurs due to impaired emptying of the gallbladder).</p> <p>Review of Resident R51's MDS (Minimum Data Set) dated May 21, 2025, revealed that resident has a BIMS (Brief Interview for Mental Status) of 15, indicating resident is cognitively intact.</p> <p>Review of Resident R51's hospital records dated June 12, 2025, revealed resident had dislodged cholecystostomy tube (Biliary drain) and that resident was sent to IR (interventional radiology) to have drain replaced.</p> <p>Interview with Employee E2 on Director of Nursing on July 15, 2025, at 1:20pm confirmed that the facility failed to report the Resident R51's allegation of neglect received for June 12, 2025.</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** Based on review of clinical records, facility policy, and staff and resident interviews, it was determined that the facility failed to ensure the timely acquisition and administration of a prescribed pain medication to meet the needs of one of four residents reviewed for pain management (Resident R64). Findings include: Review of facility policy titled Pharmacy Services, revised 2019, revealed pharmacy services are available to residents 24 hours a day, seven days a week. Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner. Nursing staff communicate prescriber orders to the pharmacy and are responsible for contacting the pharmacy if a resident's medication is not available for administration. Review of Resident 64's clinical record revealed Resident R64 was admitted to the facility on [DATE] with diagnoses that included muscle wasting and atrophy (loss of muscle mass and strength), chronic obstructive pulmonary disease (COPD- prevents airflow to the lungs, causing breathing problems), and chronic pain syndrome (condition where pain persists for more than 3 months and significantly impacts a person's physical, mental, and emotional well-being). Review of facility documentation, dated June 17, 2025, revealed Resident R64 had a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. Interview on July 14, 2025 at 10:46 a.m. with Resident R64 revealed Resident R64 has not received his/her scheduled Xtampza ER (extended-release of oxycodone, indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate) since admission. Resident R64 stated he/her takes this scheduled medication at home. Further interview on July 14, 2025 at 10:50 a.m. revealed Resident R64 stated he/she had a pain level of 8.5 (pain level scale of 1-10 with 1 being the least pain and 10 being the most pain) in his/her lower back throughout leg and pain in head. Review of Resident R64's physicians orders, dated July 11, 2025, revealed the physician prescribed Xtampza ER oral capsule 9 mg- one capsule by mouth every 12 hours related to pain. The order had a start date for the medication to be given on July 11, 2025 at 9:00 p.m. Review of Resident R64's MAR (medication administration record) revealed physician order for Xtampza was not given at the scheduled administration times as ordered by physician:-July 11th at 9:00 p.m.-July 12, 2025 at 9:00 a.m. and 9:00 p.m.-July 13, 2025 at 9:00 a.m. and 9:00 p.m.-July 14, 2025 9:00 a.m. Interview on July 15, 2025 at 12:08 p.m. with Employee E2, Director of Nursing, confirmed Resident R64 did not receive his/her scheduled pain medication due to delay in delivery from pharmacy. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services 28 Pa. Code 211.9 (f)(2) Pharmacy services</p>		