STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396076	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monumentalpostacutecare at Woodside Park	4001 Ford Road 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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on staff interview and facility documentation, it was determined that the facility failed to report to the State Survey Agency and conduct an investigation related to an allegation of neglect for one of 9 residents reviewed. (Resident R2) Findings include:A review of the Incident and Accidents Documentation policy, which was undated, revealed The facility will document unusual occurrences and events. Guidelines q. The following occurrences warrant an incident report a. Actual, alleged, or suspected abuse, including verbal abuse, oral, written or gestured, sexual abuse, harassment, coercion, assault, physical abuse, hitting, slapping, pinching, kicking, pushing, pulling, rough hanging, etc.On September 4, 2025, at 2:45 p.m., an interview was conducted with the Administrator, Employee E1, who reported that the facility was not aware of any incontinence neglect, with respect to Resident R2. Employee E1 further reported that the Human Resources Director, Employee E11, was out sick, and the facility was unable to provide the nurse aide personnel file for Employee E14, who had been terminated on August 29, 2025. Employee E1 stated that Employee E14's file would be forwarded to the surveyor via email on September 5, 2025.On September 5, 2025, at 2:00 p.m., a review of nurse aide, Employee E14's, personnel file contained an email from Employee E14 to the Nursing Home Administrator, dated August 23, 2025, at 5:53 p.m. In the email, Employee E14 reported: Resident R2, at approximately 3:00 p.m., at the start of my second shift, I found the resident seated in a Geri chair. The resident's clothing and the Hoyer pad were saturated with urine. The urine had soaked through all layers of clothing and the pad, and the chair was also wet. The Hoyer pad in use was observed to be a size not recommended for the resident's weight per the care plan. There was no indication or documentation that the resident had been toileted or changed prior to my shift.The same day an email was sent to the facility at 2:29 p.m. and again at 4:01 p.m. requesting the investigation of the above allegation of neglect. No response was received from the Administration. There was no documented evidence that the allegation of neglect was reported to the State Agency as required and that the facility conducted an investigation upon becoming aware of the allegation of neglect related to delivering timely incontinence care to Resident R2. 28 Pa. Code 201.14(a)(b) Responsibility of licensee28 Pa. Code 201. 18(b)(1)(2)(3) Management28 Pa. Code 201.29(a) Resident rights

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, clinical record review, observation, and staff interviews, it was determined that the facility failed to provide adequate supervision to prevent a fall and to ensure that an air mattress was properly fastened to the bed for two out of nine residents reviewed. (Residents R1 and R8).Findings include:A review of the undated facility policy title Incident and Accidents Documentation revealed The facility will document unusual occurrences and events. Guidelines q. The following occurrences warrant an incident report a. Actual, alleged, or suspected abuse, including verbal abuse, oral, written or gestured, sexual abuse, harassment, coercion, assault, physical abuse, hitting, slapping, pinching, kicking, pushing, pulling, rough hanging, etc.Clinical record review revealed that Resident R1 was admitted to the facility on [DATE], with diagnoses of cerebral infarction, falls, pain, acute kidney failure, encephalopathy (disease of the brain), muscle weakness, cognitive communication deficit, mixed receptive-expressive language disorder, and obesity.Review of Resident R1's Minimum Data Set (MDS-an assessment of a resident's abilities and care needs), dated August 7, 2025, revealed that Resident R1 did not have a Brief Interview for Mental Status (BIMS) score recorded, indicating that the resident was unable to participate in the assessment due to severe cognitive impairment.Review of Resident R1's care plan, initiated on March 14, 2022, revealed that the resident had a self-care deficit, requiring assistance with activities of daily living (ADLs) related to decreased cognition and generalized muscle weakness. Interventions included: two-person assistance with transfers and turning, mechanical lift with two or more persons, two-person assistance for incontinent care, repositioning in bed, and transfers with a Hoyer (mechanical) lift.A comprehensive care plan, dated August 27, 2025, further revealed that Resident R1 was at risk for falls due to decreased cognition and decreased mobility. Interventions included: Have maintenance check the mattress to ensure it is well fastened to the bed.Review of facility documentation, dated August 28, 2025, revealed an investigation was initiated on August 26, 2025 related to Resident R1's had a witnessed fall in her bedroom during routine care. At about 11:45 a.m. 2 staff members, a certified nursing aide, [Employee E4] and charge nurse were providing routine a.m./incontinence care for [Resident R1] in her bed. While turning the resident onto her right side towards the [Nurse Aide, Employee E4] suddenly the mattress shifted causing the [Resident R1] to accidentally roll out of bed to the floor mat resulting in a small hematoma to the left side of her forehead.An interview was conducted with nurse aide, Employee E4. E4 on September 4, 2025, at 11:22 a.m., revealed that on August 26, 2025, while providing incontinence care to Resident R1, I was standing approximately two feet away from Resident R1 bed and turned her towards myself. The mattress shifted, and Resident R1 fell into the two-foot gap between myself and the bed. Employee E4 further explained that he had been trained to use his body to close the gap between himself and the bed to prevent accidental falls. He acknowledged, I was too far from the bed, which allowed the resident to fall.An interview was conducted with the Maintenance Director, Employee E7 on September 4, 2025, at 12:03 p.m. who confirmed that he had placed an air mattress for Resident R1 a month ago before the fall and the mattress was secured with six straps before resident's fall on August 26, 2025.Observation conducted of Resident R8, who was also ordered to have an air mattress in room [ROOM NUMBER]B. Resident R8's mattress was not fastened to the bed with the six straps. Maintenance Director, Employee E7 confirmed this observation and reported that it is common practice in the facility for evening or night staff, when changing an air mattress for a resident, to not fasten the mattress to the bed. He acknowledged that this practice could result in the air mattress shifting. Employee E7 immediately fastened the six straps securing Resident R8's mattress to the bed.On September 4, 2025, at 2:45 p.m., an interview was conducted with the Nursing Home Administrator, Employee E1. who confirmed that Nurse aide, Employee E4, was standing approximately two feet away from Resident R1 during incontinence care, which resulted in the resident's fall. Employee E1 further confirmed that Resident R8's air mattress should have been secured to the bed with six straps.28 Pa. Code 201.14 (a) Responsibility of licensee.28 Pa. Code 211.12 (d)(5) Nursing Services.

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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. Based on review of clinical records and staff interview, it was determined that the facility failed to maintain complete documentation of resident's clinical records for one of 9 resident records reviewed (Resident R9). Findings include:A review of the Incident and Accidents Documentation policy, which was undated, revealed The facility will document unusual occurrences and events. Guidelines q. The following occurrences warrant an incident report a. Actual, alleged, or suspected abuse, including verbal abuse, oral, written or gestured, sexual abuse, harassment, coercion, assault, physical abuse, hitting, slapping, pinching, kicking, pushing, pulling, rough hanging, etc.On September 4, 2025, at 2:35 p.m., an interview was conducted with the Administrator, Employee E1, and the weekend supervisor, Employee E13. They reported that on August 24, 2025, at 6:00 p.m., an incident occurred in the front lobby involving Resident R9 during a visit with the resident's family. Employee E13, who responded to the situation, confirmed that there was no documentation in Resident R9's clinical record regarding the incident. 28 Pa. Code 201.14(a)(b) Responsibility of licensee28 Pa. Code 201.18(b)(1)(2)(3) Management28 Pa. Code 201.29(a) Resident rights