| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 396076 | A. Building<br>B. Wing | 11/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Monumentalpostacutecare at Woodside Park | 4001 Ford Road<br>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 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(continued on next page) |

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 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility policies and facility documentation, and interview with staff, it was determined the facility failed to ensure Resident R1 was free of neglect which resulted in actual harm to Resident R1 who was transferred from chair to bed without the use of a mechanical lift and sustained a left humeral fracture for one of five residents reviewed. (Resident R1) Findings include: Review of an undated facility policy titled, Abuse Policy, revealed It is the policy of the facility to protect its residents from mistreatment, neglect, abuse, misappropriation of resident property and exploitation, and that all reports of abuse will be reported to the appropriate agencies and thoroughly investigated. The policy further defined neglect as the failure of the facility, its employees or service providers to provide goods and services necessary to avoid physical harm. Review of the clinical record for Resident R1 revealed the resident had been admitted to the facility on [DATE], with diagnoses including muscle weakness and difficulty walking. Further review of Resident R1's clinical record revealed a care plan initiated on September 14, 2018, indicating the resident required the assistance of two staff for incontinent care, toileting, turning, moving up in bed and transfers with 2-persons transfer using a mechanical lift. Review of Resident R1's October 7, 2025, quarterly MDS (Minimum Data Set- comprehensive resident assessment) revealed the resident was totally dependent on the assistance of two or more staff for a chair to bed transfer. The resident was assessed with a BIMS (Brief Interview of Mental Status) of 14 which indicated the resident was cognitively intact. Review of information submitted to the State Survey Agency on October 24, 2025, revealed, on Sunday, October 19, 2025, at 1:52 p.m. it was reported Resident R1 was observed with swelling and bruising to (her/his) left upper arm and left lateral breast area. When asked about the bruises Resident R1 reported it happened sometime Friday, October 17, 2025, during a one-person transfer by male staff later identified as Licensed nurse, Employee E4, who worked on the unit that day. Resident R1 went on to say that during the transfer (she/he) felt a pop in (her/his) shoulder but felt ok once (she/he) was lying in bed. Two days later, on Sunday the swelling and bruising was noted to the left side of the resident's body and the physician was notified and ordered an in-house x-ray of the left side which was inconclusive. Resident R1 was sent out to the emergency room (ER) for detailed radiologic studies which showed the resident sustained a comminuted fracture (broken bone with multiple pieces, usually caused by severe trauma) of the proximal left humerus (proximal humerus fracture is when the top part of the upper arm bone, which is shaped like a ball, is broken. It may also be referred to as a shoulder fracture). The report further revealed Licensed nurse, Employee E4 did not follow Resident R1's plan of care for transfers which was for two-person transfer using a mechanical lift. Review of facility documentation, revealed statement from nurse aide, Employee E5, which indicated, she was on duty on the second floor on October 17, 2025, and caring for Resident R1 on the evening shift. She and another nurse aide were preparing to put Resident R1 to bed and had tried two mechanical full body lifts, which were not working, and asked the Licensed nurse, Employee E4, for help. Review of Licensed nurse, Employee E4's statement revealed that he was the charge nurse on duty on the second floor on October 17, 2025, when around 8:00 p.m. the nurse aide, Employee E5, asked him for assistance putting Resident R1 back to bed. The statement indicated when I entered [Resident R1's] room I saw that [she/he] was sitting on the lift pad in [his/her] wheelchair next to the bed with the lift next to [her/him], but the lift was not working. The space between the wheelchair and the bed was small, so I decided to quickly transfer [him/her] to the bed using a one-person lift. Review of Licensed nurse, Employee E7's written statement indicated she was on duty on the 11:00 p.m. to 7:00 a.m. shift on October 17, 2025, on the second floor. Licensed nurse, Employee E7 indicated Resident R1's son had come out of the resident's room and requested more pain medication. She told Resident R1 that (she/he) had to wait six hours until [he/she] could have more medication and that Resident R1 indicated that [she/he] did have pain in [her/his] left arm when touched but that it was not bruised at the time. Review of nurse aide, Employee E8's written statement indicated that he was caring for Resident R1 in resident's room on the morning of October 19, 2025, when he noticed that the resident's left arm was swollen when he was washing the resident. Resident R1 told him that the injury happened when a male caregiver had picked [her/him] up under [his/her] arms and put [her/him] in bed because the lift was not working. Nurse aide, Employee E8 reported the swelling to the charge nurse. Review of Licensed nurse, Employee E9, written statement revealed that she was the charge nurse on the 7:00 a.m. to 3:00 p.m. shift on October 19, 2025, when nurse aide, Employee E8 reported to her that |