

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER Monumentalpostacutecare at Woodside Park		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>47973</p> <p>Based on review of facility documentation, review of clinical records, and interviews with staff, it was determined that the facility failed to notify the Office of the State Long-Term Care Ombudsman of facility-initiated emergency transfers to the hospital and that a resident's representative was made aware of a facility-initiated transfer, for one of four residents reviewed. (Residents R136)</p> <p>Findings Include:</p> <p>Review of nursing notes for Resident R136 dated April 21, 2024, at 11:37 p.m. revealed that the resident had a seizure and was transferred to a local hospital for evaluation at approximately 11:25 a.m.</p> <p>Further review revealed a note, dated July 24, 2024, at 6:27 a.m., which indicated that Resident R136 was admitted to the local hospital for altered mental status on July 23, 2024.</p> <p>Further record reviews for Residents R136 revealed that no documentation was available for review at the time of the survey to indicate that the Office of the State Long-Term Care Ombudsman was notified of the facility-initiated emergency transfers and discharges.</p> <p>Review of documentation provided by the Social Services Director, Employee E9, on January 10, 2025, at 1:12 p.m., revealed the Office of the State Long Term Care Ombudsman was not made aware Resident R136's facility-initiated emergency transfers to the hospital as required.</p> <p>Further interview confirmed that the facility failed to notify the residents representative of the transfer and reasons for the move in writing and in a language and manner they understand.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(2) Management</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 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>47973</p> <p>Based on clinical record review and interviews with staff, it was determined that the facility failed provide appropriate bed hold notice to a resident's representative of a facility-initiated transfer to the hospital for one of four residents reviewed related to transfers (Resident R136).</p> <p>Findings include:</p> <p>Review of Resident R136's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated February 26, 2024, revealed that the resident had severely impaired cognition.</p> <p>Review of nursing notes for Resident R136 revealed a note, dated April 21, 2024, at 11:37 p.m. which indicated that the resident had a seizure and was transferred to a local hospital for evaluation at approximately 11:25 a.m.</p> <p>Further review revealed a note, dated July 24, 2024, at 6:27 a.m., which indicated that Resident R136 was admitted to the local hospital for altered mental status on July 23, 2024.</p> <p>Review of Resident R136's clinical record revealed that there was no bed hold notice available for review in the resident's record.</p> <p>Interview with the Social Services Director, Employee E9, on January 10, 2025, at 1:12 p.m. confirmed that there were no documented evidence to indicate that Resident R136's representative was provided with written information that specified the duration of the state bed-hold policy at the time of the resident's transfer to the hospital.</p> <p>Social Services Director, Employee E9 confirmed that there was no documentation available for review at the time of the survey to indicate that the resident or her representative was notified of the bed hold policy at the time of the resident's transfer to the hospital.</p> <p>28 Pa Code 201.18(b)(2) Management</p> <p>28 Pa Code 211.5(f)(ix) Medical records</p> <p>28 Pa Code 211.12(d)(1) Nursing services</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39343</p> <p>Based on observation, clinical record review and interview with staff, it was determined that the facility did not ensure that resident assessments accurately reflected resident status related to restraints for two of 34 records reviewed (Residents R9, R38).</p> <p>Findings include:</p> <p>Review of clinical documentation revealed that Resident R9 was most recently admitted to the facility on [DATE], and had diagnoses of schizophrenia (a chronic mental illness characterized by a disconnect from reality, disorganized thinking and speech, and changes in behavior), anxiety, and dementia (progressive degenerative disease of the brain) Review of the most recent MDS (Minimum Data Set- a periodic assessment of resident care needs) completed on September 22, 2024, revealed that in section P- Restraints and Alarms, it was documented that the resident's chair prevents rising and that this restraint was used less than daily.</p> <p>Observations conducted on January 8, 2025, at 1:15 p.m. revealed that Resident R9 was ambulating at will through the unit.</p> <p>During an interview with Employee E1, the Nursing Home Administrator, and Employee E2, the Director of Nursing, on January 9, 2025 at 1:13 p.m., they stated that the facility was restraint-free and confirmed that the resident has never had a restraint. They confirmed that the MDS was coded inaccurately.</p> <p>Review of clinical documentation revealed that Resident R38 was admitted to the facility on [DATE], and had diagnoses including Anxiety Disorder (mental health conditions that involve persistent and excessive feelings of fear or worry), Non-Alzheimer's Dementia (Non-Alzheimer's Dementia can have complex symptoms that overlap with neurological and psychiatric disorders).</p> <p>Review of the most recent MDS (Minimum Data Set- a periodic assessment of resident care needs) completed on October 8, 2024, revealed that in section P- Restraints and Alarms, it was documented that the resident R38 used Limb Restraint in chair or out of bed, and that the restraint was used less than daily.</p> <p>Observations conducted on January 7, 2025, at 1:02 p.m., revealed that Resident R38 had no restraints.</p> <p>Review of physician order for Resident R38 did not indicate any order for restraints. On January 7, 2025, at 1:02 p.m., during an interview Resident R38 stated that he never had any restraints.</p> <p>During an interview with Employee E1, the Nursing Home Administrator, and Employee E2, the Director of Nursing, on January 9, 2025, at 1:13 p.m., they stated that the facility was restraint-free and confirmed that the resident has never had a restraint. They confirmed that the MDS was coded inaccurately.</p> <p>28 Pa Code 211.5(f)(ix) Medical records</p> <p>(continued on next page)</p>		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1) Nursing services

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39343</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to update Pennsylvania Pre-Admission Screening Resident Review (PASRR) of one resident with a new diagnosis of a serious mental disorder, out of 34 sampled residents reviewed (Residents R 103).</p> <p>Findings include:</p> <p>Review of Resident R103's clinical record revealed; the resident was admitted to the facility on [DATE], and had diagnoses including Acute Kidney Failure (Acute kidney injury happens when the kidneys suddenly can't filter waste products from the blood; when the kidneys can't filter wastes, harmful levels of wastes may build up), Injury of Unspecified Body Region, and Type 2 Diabetes Mellitus (a disease that occurs when the body doesn't use insulin properly, resulting in high blood sugar levels).</p> <p>Review of Pennsylvania Pre-Admission Screening Resident Review (PASRR- an in-depth mental health assessment to determine appropriate services and placement) Level I Form of R 103 indicated that it was completed on March 4, 2021. Under Section VIII -PASRR Level I Screening Outcome, it was stated that, individual has a negative screen for Serious Mental Illness, Intellectual Disability/Developmental Disability, or other related condition; no further evaluation (Level II) is necessary.</p> <p>Further review of diagnosis sheet in the clinical records of R 103 revealed, on June 4, 2021, a new diagnosis of Undifferentiated Schizophrenia was included. (people with undifferentiated schizophrenia exhibit symptoms of more than one type of schizophrenia; these may include delusions, paranoia, hallucinations, and other symptoms that interfere with a person's sense of reality).</p> <p>Additional review of clinical records did not provide any documented evidence to indicate that following the diagnosis of a new, serious mental disorder, the facility considered or addressed a referral to the appropriate state-designated authority for a Level II PASARR evaluation and determination; or to update the PASRR.</p> <p>During an interview on January 9, 2025, at 10: 52 a.m., the Director of Social Services, Employee E9, confirmed the above stated finding.</p> <p>28 Pa. Code 211.5(f)(iv) Medical records</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44882</p> <p>Based on observation, clinical record review and interview with staff and residents, it was determined that the facility did not develop a comprehensive care plan related to dementia, smoking, and pain management for 3 of 34 records reviewed (Residents R7, R28, R155).</p> <p>Findings include:</p> <p>Review of clinical records revealed that Resident R7 was admitted to the facility on [DATE], and had diagnoses that included Type 2 Diabetes Mellitus (a disease that occurs when the body doesn't use insulin properly, resulting in high blood sugar levels), and Dementia (a general term for a group of brain conditions that cause a decline in mental abilities).</p> <p>Review of Resident R7's current care plan revealed that there was no care plan was developed for the dementia care.</p> <p>During an interview with the Nursing Home Administrator, and the Director of Nursing, on January 13, 2025, at 12:20 p.m., it was confirmed that no care plan was developed for the Dementia care needs of Resident R7.</p> <p>Observations conducted on January 10, 2025, at 9:53 a.m. revealed that the Resident R28 went to smoke breaks and was a smoker.</p> <p>Review of Resident R28's current care plan revealed that there was no care plan was developed for safety during smoking for Resident R28</p> <p>Interview with the Unit manger, Nurse Employee E14, on January 10, 2025, 11:40 a.m. revealed that Resident R28 was a smoker and was not sure why Resident R28 was not care planned for smoking.</p> <p>Observations conducted on January 8, 2025, at 1:30 p.m. revealed that the Resident R155 appeared to be in pain, with facial grimacing and negative verbalizations noted.</p> <p>Review of clinical documentation revealed that Resident R155 was most recently admitted to the facility on [DATE], and had diagnoses that included, prostate cancer, and septic pulmonary embolism (a blood clot in the lung which had become infected).</p> <p>Review of the resident's physician orders revealed that the resident had an order for hospice services dated November 1, 2024, related to his stage 4 prostate cancer. In addition, medications were ordered for pain management, including Gabapentin Capsule 300 MG (milligrams) Give 1 capsule by mouth three times a day for pain, dated October 26, 2024, and Morphine Sulfate (Concentrate) Solution 20MG/ML Give 0.25 ml by mouth every 3 hours as needed for pain, dated November 1, 2024. Review of the resident's care plan revealed that no care plan had been developed to address pain related to cancer diagnosis.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Employee E1, the Nursing Home Administrator, and E2, the Director of Nursing, on January 13, 2025 at 12:25 p.m., they stated that it was the expectation of the facility that a care plan should be developed for all resident care needs and confirmed that none was developed for pain for Resident R155.</p> <p>28 Pa Code 211.11(d) Resident care plan</p> <p>28 Pa Code 211.12(d)(1) Nursing services</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44882</p> <p>Based on clinical record review and interview with staff, it was determined that the facility did not ensure that care plans were updated in a timely manner for one of 34 records reviewed related to hospice (Resident R31).</p> <p>Findings include:</p> <p>Review of clinical documentation revealed that Resident R31 was admitted to the facility on [DATE], and had diagnoses including, congestive heart failure (an accumulation of fluid around the heart which makes it more difficult for the heart to beat effectively), ventricular tachycardia (a heart rhythm where the ventricles constrict abnormally fast, putting the resident at risk of cardiac arrest), and presence of pacemaker (a device implanted into the chest to regulate heart rhythm).</p> <p>Further review revealed a physician order dated October 10, 2023, which read Pacemaker .to be turned off due to hospice status. Review of the care plan revealed that it had been updated that same day to read the same. A physician order was found to discontinue hospice care dated December 2, 2024. As of January 10, 2025, the care plan had not been updated to reflect this change in status as it related to the resident's pacemaker.</p> <p>Interview with Employee E1, the Nursing Home Administrator, and Employee E2, the director of nursing, on January 13, 2025, at 2:15 p.m. revealed that the expectations of the facility are that care plans are to be reviewed and updated timely with every major change, including signing on to or discontinuing hospice care. It was confirmed that this care plan item had not been updated as required.</p> <p>28 Pa. Code 211.10 (d) Resident care policies</p> <p>28 Pa. Code 211.12 (d)(5) Nursing services</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>46106</p> <p>Based on review of personnel records and interview with staff, it was determined that the facility did not provide requested evidence of competency trainings for licensed nursing staff.</p> <p>Findings include:</p> <p>On January 10, 2024, at 1:45 p.m. the surveyor requested skills competency evaluations for Licensed Nurses. The requested skills were to be related to medication administration, dementia and behavioral, catheter, tracheostomy care, wound care, and abuse prevention and reporting.</p> <p>In an interview on January 10, 2024, at 1:54 p.m. with Educator, Employee E12, stated that the facility was unable to supply the surveyor with all the requested skills competencies for the nurses, stating that they didn't have them.</p> <p>28 Pa. Code: 211.12(d)(1) Nursing services</p> <p>28 Pa. Code 211.12(d)(5) Nursing services</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** 44882</p> <p>Based on closed clinical record review, and interviews with staff, it was determined that the facility failed to ensure that controlled medications were disposed in a timely manner for one of 3 closed records reviewed (Resident R162).</p> <p>Findings include:</p> <p>Review of clinical documentation for Resident R162 revealed that she was admitted to the facility on [DATE], and discharged from the facility against medical advice on October 24, 2024. While a resident, she had an order for Morphine Sulfate (Concentrate) Solution 20 MG/ML Give 0.25 milliliter by mouth every three hours as needed for Pain/SOB hospice, and Lorazepam Concentrate 2 MG/ML Give 0.25 milliliter by mouth every 6 hours as needed for anxiety/agitation. Morphine is a Schedule 2 controlled medication, which are classified as high potential for misuse, dependence, and addiction. Lorazepam is a schedule 4 controlled substance which has a lower potential for abuse than schedule 2 substances, however, the abuse of a schedule 4 medication may lead to physical or psychological dependence.</p> <p>Further review of resident records revealed a nursing note from January 9, 2025, which stated Resident discharged home. All medications: albuterol sulfate neb 2.5 mg/3 ml #4, fluticasone Propionate suspension 50 mg/act #1, hyoscyamine sulfate 0.125 mg #4, loratadine 10 mg #6, lorazepam 2 mg/ml #20 ml, losartan potassium 25 mg #6, morphine sulfate 20 mg/ml #15 ml, prochlorperazine 10 mg #5, vitamin d3 1250 mcg #6, triamterene & hydrochlorothiazide 37.5-25 mg #7. All medications counted and destroyed. The Controlled Medication Accountability forms for both the morphine and the lorazepam were signed as wasted/destroyed on January 9, 2025.</p> <p>Interview with the Director of Nursing, Employee E2, on January 13, 2025, at 1:30 p.m. confirmed that the medications for Resident R162 had not been disposed of until January 9, 2025, 11 weeks after the resident was discharged, which Employee E2 confirmed was not considered to be a timely manner.</p> <p>28 Pa Code 211.9(a)(1) Pharmacy services</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47973</p> <p>Based on observations, interviews with staff, and a review of facility procedures, it was determined that the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety.</p> <p>Findings include:</p> <p>Review of facility policy titled, Storage of Refrigerated Foods Policy, revised March 9, 2024, indicated that staff must label and note pull date on all food items when removing from freezer. Further review revealed that refrigerated food held for more than 24 hours will be marked to indicate the date the food will be consumed or discarded.</p> <p>A follow-up tour of the main kitchen was conducted on Thursday, January 9, 2025, at 10:45 p.m. with the Food Service Director (FSD), Employee E13.</p> <p>Observations at 10:46 a.m. revealed a bucket with soapy water and rag was standing on the preparation table in the cooking area meanwhile the cook was assembling sandwiches.</p> <p>Observations of the main refrigerator at 10:50 p.m. revealed three rolls of 10-pound ground beef, a bag of raw mixed chicken, and a bag of raw chicken thighs were unlabeled and undated. Interview with the FSD revealed that the ground beef rolls, mixed chicken, and chicken thighs were pulled from the freezer to thaw on Tuesday, January 7, 2025. Further interview acknowledged that these food items should have been dated with a pull date.</p> <p>Further observations at 10:55 p.m. revealed dishes were drying on the tray line with limited all-around airflow. Prepared hot food was observed on the tray line by the drying dishware. Follow up interview confirmed that drying racks should have been utilized to allow proper draining and all-around airflow.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(3) Management</p>

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dispose of garbage and refuse properly.</p> <p>47973</p> <p>Based on observations and an interview with staff, it was determined that the facility did not ensure that garbage and refuse was disposed of properly.</p> <p>Findings include:</p> <p>An initial tour of the Food Service Department was conducted on Tuesday, January 7, 2025, at 9:57 a.m. with Employee E16, Cook, which revealed that the blue dumpster was fully open and overflowing with cardboard boxes. Additional piles of cardboard and boxes was observed on the ground on all four sides of the dumpster.</p> <p>Follow up observation with the Food Service Director (FSD), Employee E13, conducted on Thursday, January 9, 2025, at 10:32 a.m. revealed that the blue dumpster remained fully open and overflowing with cardboard and carboard boxes. Additional piles of cardboard and boxes was observed on the ground on all four sides of the dumpster.</p> <p>Interview with the FSD at 10:32 a.m. on Thursday, January 9, 2025, confirmed the above findings.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(3) Management</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>39343</p> <p>Based on observations, review of facility policies, review of facility documentation, clinical record review and interviews with staff, it was determined that the facility failed to maintain an effective infection control program related with Transmission Based Precautions for one of 34 residents reviewed ((Resident R113).</p> <p>Findings include:</p> <p>Review of literature review revealed that Enhanced Barrier Precautions are infection control interventions designed to reduce the transmission of novel or Multi-Drug Resistant Organisms. Enhanced Barrier Precautions require to employ the use of targeted personal protective equipment (PPE) during high contact patient/resident activities.</p> <p>On January 10, 2025, at 2:39 p.m., review of the door of the room of Resident R113 revealed a guiding description pasted on it, indicating that Resident R113 was on Enhanced Barrier Precautions.</p> <p>Review of the physician order for Resident R113 revealed that Resident R113 had an order dated July 11, 2024, to Cleanse G-tube site daily with soap and water, every day-shift.</p> <p>Observation on January 10, 2025, at 2:41 p.m., revealed that a Licensed Nurse, Employee E17, was cleansing Resident R113's G-tube site. Employee E17 did not wear PPE, even though Resident R113 was on Enhanced Barrier Precautions; and the same information was noted on the door of the resident room. At the time of the finding, the observation was confirmed with Employee E17.</p> <p>28 Pa Code 211.10(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p>		