| 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 | 12/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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.

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policies, facility documentation and interview with staff, it was determined that the facility failed to ensure that hot water temperatures in resident bathroom hand sinks and shower rooms were maintained at a safe temperature. This failure placed residents on three of three nursing units at risk of serious injury from a burn and resulted in an Immediate Jeopardy situation. (First floor East, Second floor East and West) Findings include:Review of facility policy titled Physical Environment Common A, dated January 2, 2025, revealed the facility will be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. The facility will meet the applicable provisions of the 1985 edition of the life safety code of the National Fire Protection Association. Hot water outlets accessible to residents shall be controlled so that the water temperature at the outlets does not exceed 110 degrees Fahrenheit. Observations conducted of the shower room on unit one East with Maintenance Director Employee E6 on December 8, 2025, at 10:20 a.m. failed to reveal a thermometer in the shower room. The hot water temperature tested 117.3 degrees Fahrenheit. Further observations of shower room [ROOM NUMBER]nd floor East failed to reveal a thermometer in the shower room. The hot water at the hand sink in the shower room was turned on and felt excessively hot to the touch. Hot water temperatures were taken of the hand sink and the shower by Maintenance Director, Employee E6 on December 8, 2025, at 10:30 a.m. The hot water temperature in the sink registered 118.2 degrees Fahrenheit. The shower temperature was 117.8 degrees Fahrenheit. The Maintenance Director, E6 confirmed the temperatures of the hot water were too high. Observation conducted in the shower room on Second floor [NAME] on December 8, 2025, at 10:50 a.m. in the company of Director of Maintenance, Employee, E6 failed to reveal a thermometer located in the shower room. Hot water temperatures were taken of the shower as well as hand sink. The hand sink temperature was 120.7 degrees Fahrenheit, and the shower temperature was 115.7 degrees Fahrenheit. Observation of the boiler room on December 8, 2025, at 11:15a.m. with Maintenance Director, Employee E6 revealed two domestic water storage tanks. Observation of boiler #1 revealed it was set at 125 degrees Fahrenheit.Observation conducted of boiler #2 which revealed the boiler was at 125 degrees Fahrenheit. Interview with Director of Maintenance at the time of the observation confirmed the incoming water temperature of the boilers was high and should be set at 110 degrees Fahrenheit. Observations conducted of hand sinks in resident rooms by the Maintenance Director, Employee E6 on all nursing units as follows: December 8, 2028 between 10:30 a.m. and 11:30 a.m. of First floor East and [NAME] and Second floor East and [NAME] revealed the following high hot water temperatures: room [ROOM NUMBER] registered a temperature of 118.2 degrees Fahrenheitroom [ROOM NUMBER] registered a temperature of 117.5 degrees Fahrenheitroom [ROOM NUMBER] registered a temperature of 119.6 degrees Fahrenheitroom [ROOM NUMBER] registered a temperature of 120 degrees Fahrenheitroom [ROOM NUMBER] registered a temperature of 115.3 degrees Fahrenheitroom [ROOM NUMBER] registered a temperature of 118.7 degrees Fahrenheitroom [ROOM NUMBER] registered a temperature of 120.7 degrees Fahrenheitroom [ROOM NUMBER] registered a temperature of 116.6 degrees Fahrenheit<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 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of the water temperature logs was completed for the months of November and December 3, 2025. revealed that there was no temperatures out of ranges, all documented to be under the temperature of 110 degrees Fahrenheit. Interview with Maintenance Director, Employee E6 on December 8, 2025, at 11:20 a.m. revealed he was aware the temperatures are supposed to be under 110 degrees Fahrenheit but had turned up the temperatures on the boilers to accommodate the complaints of residents of water temperatures are too cold. Maintenance Director, Employee E6 revealed he adjusted the temperature approximately one month prior to observations. On December 8, 2025, at 11:20 a.m., an interview conducted with Nursing aide, Employee E5 revealed, Employee E5 uses his hand to test the water temperature and confirmed that he has not used water thermometers as they are not available in the showers. On December 8, 2025, at 11:24 a.m., an interview conducted with Unit manager, Employee E4 revealed the nursing station did not have water thermometers available to test the water temperatures when providing showers. Based on the above findings, Immediate Jeopardy to the safety of the residents was identified to the Nursing Home Administer and assistant Nursing Home Administrator on December 8, 2025, at 2:31 p.m. for failure to ensure safe hot water temperatures were maintained on the first and seconds floors nursing units. The Nursing Home Administrator, Employee E1 was provided with the Immediate Jeopardy template, and an immediate action plan was requested. On December 8, 2024, at 5:31 p.m. the facility developed and submitted the following corrective action plan.-The policy will be updated to include safe processes for monitoring hot water. -The facility shall maintain what are delivered to residents use area including bathrooms, showers, and sinks at 110 degrees Fahrenheit (43 degrees Celsius) or below. This standard complies with safety regulations for long-term care environments and promotes resident safety. -If temperature of water temperature exceeds 110-degree Fahrenheit, staff must immediately notify maintenance supervisor and charge nurse. -Post a Do Not Use Hot Water sign until the temperature issue is corrected. -Document the corrective steps taken and recheck the temperature before returning the fixture to service. -Thermometers will be available on each unit for staff use. -Hot water systems were calibrated to deliver water not to exceed 110 degrees Fahrenheit at all resonant use fixtures. -The maintenance department shall ensure thermostatic mixing valves are installed and function properly in all areas where residents have access to hot water. -All water in resident rooms and showers were checked, and all were below 110 degrees Fahrenheit. -Temperatures shall be recorded on the water temperature log, including location, date, time, and staff initials. -Temperature logs will be kept on file at the facility for review by regulatory agencies. -Nursing staff will be in-serviced by Nurses, Managers, or designee, on the importance of checking water temperatures prior to assisting residents with bathing or other hygiene care. (90% of the staff will be in service by December 9, 2025, 100% by December 11, 2025) -All water in resident rooms and showers will be checked by maintenance daily for 5 days to ensure compliance to be completed by December 13, 2025. -Water temperatures shall be checked weekly in representative sample of resident areas (minimum three per wing/unit). All water log checks will be reported in monthly QAPI (Quality Assurance Improvement Plan) -Maintenance department was educated on importance of maintenance water system temperatures below 110 degrees. Education was completed December 8, 2025. The facility's action plan was submitted and accepted on December 8, 2025, at 5:31 p.m. Staff interviews were conducted on December 9, 2025, between the hours of 8:00 a.m. and 3:30 p.m. with nursing staff to verify the implementation of the immediate action plan. Nursing staff was able to verbalize the facilities updated policy, including that with their temperatures should not exceed 110 degrees Fahrenheit, what to do if temperatures were found to be too high and how often temperatures should be checked, nursing staff were able to demonstrate proper use of checking water temperatures and they have had sufficient thermometers available for use. Maintenance staff and supervisory staff were observed checking water temperatures and completing audit logs. The hot water at hand sinks throughout the facility were tested and verified and did not exceed 110 degrees Fahrenheit. Water temperature logs were reviewed and revealed appropriate water temperatures. Staff education documentation was received, (continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | and it was confirmed the facility in-service their staff on proper hot water temperatures. Following verification of the implementation of the immediate action plan, review of water temperature logs and review of staff education documentation the immediate jeopardy was lifted on December 10, 2025, at 11:05 a.m. 28 Pa. Code 201.14(a) Responsibility of Licensee28 Pa. Code 201.18(a) Management28 Pa. Code 201.18 (b)(1) Management28 Pa. Code 201.18(b)(3) Management28 Pa. Code 211.12(d)(3) Nursing Services |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review facility policies and staff interview, it was determined that the facility failed to maintain a safe, clean and homelike environment in resident care areas for two of three nursing units observed (1st floor East and 2nd floor [NAME] Nursing units). Findings Include:Review of facility policy Physical Environment: Common Areas dated January 2025, revealed, the facility will be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. On December 8, 2025, at 1:25 p.m. unit manager, Employee E8 confirmed that room [ROOM NUMBER]B had no grid on the heating unit and the cover of the heating unit was coming off. On December 9, 2025, at 12:45 p.m. the Maintenance Director, Employee E6, confirmed that room [ROOM NUMBER]B bedside dresser was broken on the sides of the dresser, there was a large amount of woodchip inside of the first drawer. room [ROOM NUMBER]B dresser had 3 broken shelves as the railing were dispatched and were not closing appropriately. The trashcan also had no liner. Observations during an initial tour of the 2-West nursing unit on December 8, 2025, at 10:30 a.m. revealed: In room [ROOM NUMBER], bed A, the mattress had a large rip along the right side, and the privacy curtain was soiled. In room [ROOM NUMBER], the blinds were observed to be broken and bent. Observations inside the 2-West utility closet revealed the faucet was leaking. Observations in room [ROOM NUMBER], the B-bed dresser had a front panel missing on a drawer. Observations made during follow-up visits to 2-West nursing unit on December 9, 2025, revealed: At 11:06 a.m. observations in room [ROOM NUMBER] revealed Resident R127 was on a tracheostomy and feeding tube. The bedside nightstand, with all the tracheostomy equipment on top, had significant build up of dirt and debris. Further, Resident R127's bed frame was visibly soiled with debris and tube feeding formula. Further observations in room [ROOM NUMBER] revealed the floor surrounding Resident R127's tube feeding pole had significant dust/debris build up. Interview on December 9, 2025, at 11:06 a.m. with Registered Nurse, Employee E10, confirmed the dirty environment of Resident R127's room. At 12:34 p.m. observations in room [ROOM NUMBER] revealed Resident R62 had no dresser or table to support his/her lamp (the lamp was placed directly on the floor). Further, Resident R62's dresser drawers were broken. 28 Pa. Code 201.14 (a) Responsibility of licensee. |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from the wrongful use of the resident's belongings or money.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical records, and staff and resident interviews it was determined that the facility failed to safeguard medications tor one of 29 residents reviewed (Resident R7). Findings Include: Review of Resident R7's Annual Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated September 30, 2025, revealed the resident had a diagnosis of chronic obstructive pulmonary disease (COPD - progressive lung disease that makes it hard to breathe). Continued review of Resident R7's MDS dated [DATE], revealed the resident was cognitively intact. Review of Resident R7's comprehensive care plan revised February 15, 2025, revealed the resident had the potential for inadequate respiratory function. Intervention dated July 26, 2022, indicated to provide medication as ordered. Review of Resident R7's physician order summary revealed an order dated January 5, 2025, to administer Breztri Aerosphere Inhalation Aerosol (prescription inhaler), two times per day. During an interview on December 9, 2025, at 2:10 p.m. with Resident R7, the resident reported he/she has not received his/her inhaler in weeks. Per Resident R7, the nursing staff lost the inhaler. Review of Resident R7's medication administration record revealed the inhaler was first documented as not available on November 18, 2025, by Licensed nurse, Employee E13. Continued review of Resident R7's medication administration record revealed licensed nurse, Employee E13, consistently documented the inhaler as not available from November 18, 2025, through December 9, 2025. Review of Resident R7's entire clinical record revealed no documented evidence that the physician was notified of the unavailable and subsequently missed medication. Interview on December 9, 2025, at 2:15 p.m. with Licensed Nurse, Employee E13, confirmed Resident R7's inhaler was not available. Licensed Nurse, Employee E13, reported that pharmacy will not refill the inhaler because insurance will not cover the cost of a new one until December 11, 2025. Interview on December 10, 2025, at 12:10 p.m. with the Director of Nursing, Employee E2, revealed Resident R7's inhaler was last dispended by the pharmacy on November 18, 2025, for a 30-day supply. Director of Nursing, Employee E2, confirmed that Resident R7's inhaler was misplaced. Continued interview on December 10, 2025, at 12:10 p.m. with the Director of Nursing, Employee E2, revealed nursing staff should have notified the Director of Nursing about Resident R7's misplaced inhaler so that the facility could replace it. Further interview with Licensed Nurse, Employee E13, on December 10, 2025, at 12:45 p.m. confirmed Resident R7's inhaler had been missing since November 18, 2025. 28 Pa. Code 211.9 (a)(1) Pharmacy services. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>Based on record review and staff interviews, the facility failed to ensure that PRN (as needed) orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluated the resident for the appropriateness of the medications for one of five residents reviewed. (Resident R10).Findings Include:Review of FDA (Food and Drug Administration) (The United States Food and Drug Administration (FDA), a federal agency within the Department of Health and Human Services, protects public health through the regulation of foods, drugs, cosmetics, and medical devices) guidance for Haldol revealed that, HALDOL (haloperidol) is indicated for use in the treatment of schizophrenia. Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death.Review of Resident R10's October 2025 through December 2025 physician orders revealed multiple PRN orders for Haldol injection (a prescription first-generation antipsychotic medication used to treat conditions such as schizophrenia) 5 mg/ml, to be given by intramuscular every six hours as needed for, each entered for a 14-day period as follows:Order started on October 31, 2025 (October 31, 2025 - November 14, 2025)Order started on November 14, 2025 (November 14, 2025- November 28, 2025)Order active on December 1, 2025 (December 1, 2025 - December 15, 2025)Further review revealed no documentation from the attending physician or prescribing practitioner evaluated the resident for the appropriateness of the medication for continued use as required by S483.45(e)(5).Interview with Director of Nursing, Employee E2 on December 10, 2025, at 2:00 p.m. confirmed that the medication order was renewed for Resident R10 after 14 days of the order multiple times. Employee E2 confirmed that there was no documentation from the attending physician or prescribing practitioner evaluated the resident for the appropriateness of the medication for continued use.28 Pa. Code 211.12(d)(1)(3) (5) Nursing services |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 discharge which occurred Against Medical Advise (AMA), attempts to provide discharge instruction, assess resident's capacity to make decision, attempts to contact the resident's representative, and notify the physician, for 1 of 2 residents reviewed (Residents R166).Findings include:Review of facility policy Admission, Transfer and Discharge,' undated policy, indicated Transfer and discharge include movement of resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge dos does not refer to movement of a resident to a bed within the same certified facility.On December 11, 2025, at 10:12 a.m., the Social Services Director, Employee E9, confirmed that Resident R166 was admitted to the facility on [DATE], and discharged on September 27, 2025, with an AMA status. The reviewed clinical record did not contain documentation that the facility attempted to provide discharge summaries, notify the physician, assess the resident's capacity to make decisions, or notify the family representative. In addition, there was no documentation showing that the Office of the State Long-Term Care Ombudsman was notified.28 Pa Code 201.29(a)(c.3)(2) resident rights |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility documents, observations, review of clinical records, and interviews with staff, it was determined that the facility failed to ensure the resident's care plan was updated and revised to address a resident's diagnosis of legal blindness and required assistance with eating for one of 29 residents reviewed. (Resident R143) Findings include:Review of the Resident R 143's quarterly Minimum Data Set (MDS-a federally mandated assessment tool for all residents), dated November 25, 2025, revealed the resident was admitted to the facility on [DATE], with diagnoses including legal blindness and cerebrovascular accident (CVA)with left hemiplegia(a stroke that caused one sided paralysis to the left side of his body). The MDS assessment indicated the resident was dependent for most functional abilities. The resident was assessed as requiring total assistance with eating, which was defined as the helper performing all of the effort with the resident performing none of the effort, or requiring the assistance of two or more helpers to complete the activity. Review of the resident's care plan dated June 21, 2024, revealed the resident was identified as having a self-care deficit requiring assistance with activities of daily living (ADLs) related to contractures, decreased mobility, decreased vision, and weakness. Continued review of the resident's care plan did not address the resident's need for assistance related to the resident's legal blindness, specifically with eating. Observation on December 10, 2025, at 12:30 PM revealed Resident 143 was in his room with a lunch tray set up over the bed. The resident requested assistance with his meal. The resident was observed with food in his hands and on the tray, indicating the resident was not receiving the required assistance with eating. Interview with Licensed Nurse Employee E12 December 10, 2025, at approximately 12:35 PM revealed the nurse stated the resident is typically fed his meals and confirmed there was no staff assisting the resident at the time of the observation. 28 Pa Code 211.10(a)(b) Resident Care Policies 28 Pa. Code 211.12(d)(5) Nursing Services |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, and staff and resident interviews it was determined that the facility failed to implement physician orders related to high blood sugars for one of 29 residents reviewed (Resident R7).Findings include: Review of facility policy Diabetic Management revised August 2013 revealed hyperglycemia (high blood sugar) is defined as a blood glucose level greater than 300. Per the facility policy, the glucose parameter levels indicate if a blood sugar is greater than 300 than the physician should be notified. Documentation of the event, along with the outcome, should be included in the nurse's progress note. Review of Resident R7's Annual Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated September 30, 2025, revealed the resident had a diagnosis of diabetes mellitus. Continued review of Resident R7's MDS dated [DATE], revealed the resident was cognitively intact. Review of Resident R7's physician order summary revealed an order dated February 3, 2023, for Accu Checks (refers to the process of measuring blood glucose levels) before meals and at bedtime. The directions specify to call the physician if glucose is less than 60 or greater than 350. During an interview on December 9, 2025, at 2:10 p.m. with Resident R7, the resident reported a history of elevated blood sugars, especially in the morning. Review of Resident R7's medication administration revealed the resident had a documented blood sugar of greater than 350 on the following dates and times: 11/3/2025 at 7:30 a.m. blood glucose level of 439 11/6/2025 at 7:30 a.m. blood glucose level of 386 11/6/2025 11:30 a.m. blood glucose level of 423 11/10/2025 21:00 p.m. blood glucose level of 379 11/15/2025 7:30 a.m. blood glucose level of 469 12/1/2025 at 7:30 a.m. blood glucose level 434 12/5/2025 at 7:30 a.m. blood glucose level 383 12/5/2025 at 11:30 a.m. blood glucose level of 422 12/7/2025 at 7:30 a.m. blood glucose level of 400 Review of Resident R7's entire clinical record revealed no documented evidence that the physician was made aware of elevated blood sugars. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(10(5) Nursing services |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>Based on observation and staff interview, it was determined that the facility failed to ensure that tracheostomy equipment was properly maintained for one of one resident receiving tracheostomy care. (Resident R127)Findings include:Findings Include:Observation of Resident R127 on December 9, 2025, at 10:01 a.m. revealed that the resident was on a tracheostomy. It was revealed that the tracheostomy tube was not dated to indicate the date it was last changed. Further observation revealed that the oxygen tubing was not dated. It was also revealed that the tracheostomy tube was placed in a container, and the container was dirty. Continued observation revealed that the trach collar and the dressing around the stoma were not dated to indicate the date of the dressing change. Observation of the tracheostomy equipment and the humidifier revealed that the last inspection date for the humidifier was February 14, 2020, and the next inspection due date was February 14, 2021. Continued observation revealed that the suction machine was inspected on July 29, 2025, and the inspection due date was also July 29, 2025, indicating that both pieces of respiratory equipment were past their inspection due dates. Interview with the unit manager, Employee E10, on December 9, 2025, at 10:30 a.m. confirmed that the staff should change the tracheostomy tubing and date it to indicate the date it was changed. The employee also confirmed that the tracheostomy dressing should be dated to indicate the change date. The employee further confirmed that the tracheostomy equipment was past the quality inspection due date. 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services |

| 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 | 12/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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.

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility policy and interviews with staff, it was determined that the facility failed to maintain effective communication with a dialysis provider for one of two residents reviewed receiving hemodialysis. (Residents R82).Findings Include:Review of facility policy titled Hemodialysis, undated, states, Dialysis pre and post treatment summaries will be communicated to facility. A review of Resident R82's record revealed that the resident was admitted to the facility on [DATE], with the diagnosis of End Stage Renal Disease. On December 9, 2025, at 2:37 p.m., an interview with the Director of Nursing, Employee E2, confirmed that dialysis communication for Resident R82 was requested by the facility. A binder containing communication sheets with residents' information and documentation of communication between the facility and the dialysis team was provided. Further review of the dialysis communication binder revealed that on several days the communication sheets were not fully completed. There was missing documentation specific to nursing signatures, missing date, and absent dialysis pre- and post-treatment summaries. The section titled Communication from Dialysis Center was not completed for the following dates: December 3, 2025; November 28, 2025; November 19, 2025; November 17, 2025; and November 12, 2025. 28 Pa. Code 211.12 (d)(1) Nursing services |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>Based on review of clinical records it was determined that the facility failed to timely implement behavioral health interventions for one of five residents reviewed for behavioral/emotional health (Resident R4).Findings:Review of Resident R4's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated September 30, 2025, revealed the resident had diagnoses of dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), depression (mood disorder characterized by low mood, a feeling of sadness, and a general loss of interest in thing), and bipolar disease (extreme swings in mood and thought). Review of Resident R4's clinical record revealed a psychiatry note dated November 4, 2025, by Psychiatric Mental Health Nurse Practitioner, Employee E14, that revealed the resident was being seen for evaluation and management of bipolar disease and dementia. Per the psychiatry note, Resident R4 reported mood is all right, no sadness, and no anxiety. Resident R4 was noted to be getting out of bed more and taking walks. Further review of psychiatry note dated November 4, 2025, revealed Nurse Practitioner, Employee E14, indicated Resident R4 was tolerating a dose reduction of Risperidone (antipsychotic medication). Per Nurse Practitioner, Employee E14, risperidone can help stabilize mood and with a dose reduction could lead to a failed dose reduction in the absence of a mood stabilizer. Nurse Practitioner, Employee E14, subsequently recommended to start Depakote DR 125 milligrams (mg) by mouth (PO) two times (BID) per day for bipolar disorder and mood stabilizer. Further review of Resident R4's clinical record revealed the resident was seen for a follow-up by Nurse Practitioner, Employee E14, on November 18, 2025. Review of psychiatry note dated November 18, 2025, by Nurse Practitioner, Employee E14, revealed Previous visit recommended to start Depakote DR 125 mg PO BID for bipolar disorder mood stability in the context of reduction of Risperidone, which has not been started. Further review of psychiatry note dated November 18, 2025, revealed Resident R4 reported feeling depressed and felt like it got worse over the last couple weeks. Resident R4 reported feeling down at least daily. Continued review of psychiatry note dated November 18, 2025, by Nurse Practitioner, Employee E14, revealed recommendations again to start Depakote DR 125 mg PO BID for mood stability. Nurse Practitioner, Employee E14, also recommended to increase Mirtazapine dosage every night for depression. Review of Resident R4's clinical record revealed the resident was seen for follow up by the Psychiatric Mental Health Nurse Practitioner, Employee E14, on December 2, 2025. Review of psychiatry note dated December 2, 2025, by Nurse Practitioner, Employee E14, revealed Previous visit recommended to start Depakote DR 125 mg PO BID for Bipolar Disorder mood stability in the context of reduction of Risperidone, and to increase Mirtazapine for depression . Psychotropic regimen is unchanged from previous visit. Review of Resident R2's clinical record revealed the behavioral health interventions were subsequently implemented on December 2, 2025, about one month after the initial recommendation on November 4, 2025. 28 Pa. Code 211.12 (d)(5) Nursing services. |

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| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have a policy regarding use and storage of foods brought to residents by family and other visitors.<br><br>Based on observations, interviews with staff, and review of facility policy, it was determined that the facility failed to ensure safe and sanitary storage and handling of personal food products brought in from outside sources for 1 of 29 residents. (R45).Findings Include:Review of Facility Policy: Resident Representative/Family Provided Food undated, states Food items provided and considered perishable are to be brought into the dietary department and food will be stored in the designated area which shall be temperature controlled. 3. No food will be held for more than 2 days from the provided date. 4. Food provided will be dated and labeled including use by date not to exceed 2 days. On December 8, 2025, at 1:30 p.m., an interview was conducted with Resident R45, who had a small refrigerator next to his bed. Resident R45 was observed not to have a refrigerator thermometer inside the refrigerator or a thermometer log to monitor the refrigerator temperature. The resident also had two personal food containers inside the refrigerator that were not labeled, one food container on top of the refrigerator, and cheese in a Ziplock bag that was not labeled. Resident R45 reported that the facility did not educate him on how to maintain food items at safe temperatures when he obtained the refrigerator. On December 9, 2025, at 12:47 p.m., the Maintenance Director, Employee E6, confirmed that Resident 45's personal refrigerator did not have a thermometer. On December 9, 2025, at 12:56 p.m., an observation was conducted with the Director of Nursing, Employee E2, who confirmed the above findings: Resident R45 had a small bedside refrigerator with no thermometer and personal food containers that were unlabeled. 28 Pa. Code 201.18(b)(1) Management |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Administer the facility in a manner that enables it to use its resources effectively and efficiently.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, review of clinical records, and interviews with staff, it was determined that the Nursing Home Administrator and the Director of Nursing failed to effectively manage the facility related to ensuring that hot water temperatures in resident bathroom hand sinks and shower rooms were maintained at a safe temperature. This failure placed residents on three of three nursing units at risk of serious injury from a burn and resulted in an Immediate Jeopardy situation. (First floor East, Second floor East and West) Findings include: Review of the Nursing Home Administers (NHA) job description revealed that the NHA is responsible for the overall management and operation of the facility, ensuring that high-quality healthcare services are delivered in a safe, compliant, and resident-centered environment. The Administrator enforces all regulations related to the level of healthcare provided, resident safety, and the protection of residents' personal property and individual rights. The Administrator ensures that a sanitary, safe, and comfortable environment is maintained for all residents through effective housekeeping practices and proper maintenance of the building and grounds. The role includes providing and implementing systems and standards for both resident and employee safety, including accident-prevention programs. The NHA plans, organizes, directs, reviews, and evaluates the functions of each department using appropriate delegation and clear lines of accountability. This position assures full compliance with all federal, state, and local regulations and maintains responsibility for the overall management, safety, and integrity of the facility and makes regular rounds throughout the building to verify that appropriate care, environmental conditions, and regulatory standards are consistently being met. Review of the Director of Nursing (DON) job description revealed it is the DON is responsible for administering and overseeing all nursing programs to ensure that high standards of patient care are consistently maintained. The DON advises medical staff, department heads, and facility administrators on all matters related to nursing services. The Director of Nursing is responsible for planning, organizing, staffing, coordinating, directing, and reporting the activities of the nursing department. This includes ensuring appropriate staffing levels, maintaining quality assurance standards, implementing nursing policies and procedures, and promoting compliance with all federal, state, and local regulations. Observations conducted of the shower room on unit one East with Maintenance Director Employee E6 on December 8, 2025, at 10:20 a.m. failed to reveal a thermometer in the shower room. The hot water temperature tested 117.3 degrees Fahrenheit. Further observations of shower room [ROOM NUMBER]nd floor East failed to reveal a thermometer in the shower room. The hot water at the hand sink in the shower room was turned on and felt excessively hot to the touch. Hot water temperatures were taken of the hand sink and the shower by Maintenance Director, Employee E6 on December 8, 2025, at 10:30 a.m. The hot water temperature in the sink registered 118.2 degrees Fahrenheit. The shower temperature was 117.8 degrees Fahrenheit. The Maintenance Director, E6 confirmed the temperatures of the hot water were too high. Observation conducted in the shower room on Second floor [NAME] on December 8, 2025, at 10:50 a.m. in the company of Director of Maintenance, Employee, E6 failed to reveal a thermometer located in the shower room. Hot water temperatures were taken of the shower as well as hand sink. The hand sink temperature was 120.7 degrees Fahrenheit, and the shower temperature was 115.7 degrees Fahrenheit. Observation of the boiler room on December 8, 2025, at 11:15a.m. with Maintenance Director, Employee E6 revealed two domestic water storage tanks. Observation of boiler #1 revealed it was set at 125 degrees Fahrenheit. Observation conducted of boiler #2 which revealed the boiler was at 125 degrees Fahrenheit. Interview with Director of Maintenance at the time of the observation confirmed the incoming water temperature of the boilers was high and should be set at 110 degrees Fahrenheit. Observations conducted of hand sinks in resident rooms by the Maintenance Director, Employee E6 on all nursing units as follows: December 8, 2028 between 10:30 a.m. and 11:30 a.m. of First floor East and [NAME]<br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | and Second floor East and [NAME] revealed the following high hot water temperatures: room [ROOM NUMBER] registered a temperature of 118.2 degrees Fahrenheitroom [ROOM NUMBER] registered a temperature of 117.5 degrees Fahrenheitroom [ROOM NUMBER] registered a temperature of 119.6 degrees Fahrenheitroom [ROOM NUMBER] registered a temperature of 120 degrees Fahrenheitroom [ROOM NUMBER] registered a temperature of 115.3 degrees Fahrenheitroom [ROOM NUMBER] registered a temperature of 118.7 degrees Fahrenheitroom [ROOM NUMBER] registered a temperature of 120.7 degrees Fahrenheitroom [ROOM NUMBER] registered a temperature of 116.6 degrees Fahrenheit Review of the water temperature logs was completed for the months of November and December 3, 2025. revealed that there were no temperatures out of ranges, all documented to be under the temperature of 110 degrees Fahrenheit. Interview with Maintenance Director, Employee E6 on December 8, 2025, at 11:20 a.m. revealed he was aware the temperatures are supposed to be under 110 degrees Fahrenheit but had turned up the temperatures on the boilers to accommodate the complaints of residents of water temperatures are too cold. Maintenance Director, Employee E6 revealed he adjusted the temperature approximately one month prior to observations. On December 8, 2025, at 11:20 a.m., an interview conducted with Nursing aide, Employee E5 revealed, Employee E5 uses his hand to test the water temperature and confirmed that he has not used water thermometers as they are not available in the showers. On December 8, 2025, at 11:24 a.m., an interview conducted with Unit manager, Employee E4 revealed the nursing station did not have water thermometers available to test the water temperatures when providing showers. Based on the deficiencies identified in this report, the Nursing Home Administrator and Director of Nursing failed to fulfill essential duties and responsibilities of their position to ensure that the Federal and State guidelines and Regulations were followed, contributing to the Immediate Jeopardy situation. Refer to F689 28 PA Code 201.14 (a) Responsibility of licensee 28 Pa Code 201.18(a) Management |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observations, staff interviews, and clinical record reviews, the facility failed to ensure staff followed infection control practices by not wearing a gown during tracheostomy care and incontinence care for one of 29 residents reviewed for tracheostomy care and incontinence care (Resident R127).Findings Include: Review of the facility policy titled Enhanced Barrier Precaution revealed that Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with an MDRO, as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). High-contact resident care activities include:DressingBathing/showeringTransferringProviding hygieneChanging linensChanging briefs or assisting with toiletingDevice care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator Indwelling medical devices include, but are not limited to, central vascular lines (including hemodialysis catheters), indwelling urinary catheters, feeding tubes, and tracheostomy tubes. The policy further states that Enhanced Barrier Precautions are recommended for residents with indwelling medical devices or wounds who do not otherwise meet criteria for Contact Precautions, even if they have no history of MDRO colonization or infection and regardless of whether other residents in the facility are known to have MDRO colonization. Devices and wounds are risk factors that place these residents at higher risk for carrying or acquiring an MDRO, and many residents colonized with an MDRO are asymptomatic or not known to be colonized. Observation of Resident R127's room on December 11, 2025, at 9:30 a.m. revealed a sign outside the resident's room indicating EBP (Enhanced Barrier Precautions). Observation of Resident R127's room on December 11, 2025, at 9:30 a.m. revealed that Employee E11, Nurse Aide, was providing incontinence care. The employee was not wearing a gown, and it was observed that the employee's scrub top was touching the resident's bed. Observation of Resident R127's tracheostomy care on December 11, 2025, at 9:40 a.m. with Employee E12, Licensed Practical Nurse, and Employee E11 revealed that both employees, who were providing direct contact with the resident during tracheostomy care, were not wearing gowns as required by the facility's Enhanced Barrier Precautions policy. 28 Pa. Code 211.12(d)(1) Nursing services28 Pa. Code 211.12(d)(5) Nursing services |