| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 396101 | A. Building<br>B. Wing | 06/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Rehab at Shannondell | 5000 Shannondell Drive<br>Audubon, PA 19403 |

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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>Based on clinical record, hospital record and policy and procedure review and interviews with staff, it was determined that the facility failed to immediately inform the physician of an accident that resulted in injury for one of five residents reviewed. (Resident R1)Findings include:A review of the policy titled physician notification dated November, 2019 revealed that it was the responsibility of the facility to notify the resident's attending physician of changes in the resident's medical condition or status. The policy indicated that the charge nurse was responsible to notify the resident's attending physician when there had been an accident or incident involving the resident. The nurse was also responsible for documenting the details and observations pertinent for the physician notification. The nurse was responsible for recording any instructions given to the nurse by the physician related to the incident or accident. Clinical record review revealed that Resident R1 had fallen at 5:00 a.m., on April 28, 2025. The nursing note at 7: 39 a.m., on April 28, 2025 indicated that the licensed nurse, Employee E5, went into Resident R1's room during morning rounds and found Resident R1 in bed, eyes closed. Resident R1 was awakened with verbal stimuli and reported to the licensed nurse, Employee E5 that she fell while ambulating to the bathroom at about 5:00 a.m., on April 28, 2025. The licensed nurse, Employee E5, called the nurse aide and requested information about Resident R1's care during the time he was responsible for the resident on the overnight shift. The nurse aide, Employee E7, confirmed that the resident fell at 5:00 a.m., on the 11:00 pm to 7:00 am shift. Nurse aide, Employee E5 said that he picked the resident up off the floor and placed her in the wheelchair and took her to the bathroom, then returned the resident to the bed. The nursing aide, Employee E7, reported that he did not notify anyone of the fall for Resident R1, that occurred at 5:00 a.m., during the 11:00 pm to 7:00 am shift. Review of physician's notes dated April 28, 2025 revealed that the reason for the visit was that the resident had a fall over night and the resident was complaining of pain of the left elbow, hip and knee. The resident stated that she fell over her walker and landed on the left side. She reported to the physician that she also hit her head. The physician ordered x-rays of the left elbow, hip and knee and pain medication as needed. The physician noted that the Resident had a left shin skin tear. The physician also ordered treatment for Resident R1's skin alteration. Interview with the Director of Nursing, Employee E2, at 10:30 a.m., on June 30, 2025 confirmed that Employee E7, nurse aide, failed to immediately report to nursing staff the fall incident that took place at 5:00 a.m., on April 28, 2025 for Resident R1. The Director of Nursing also confirmed that Resident R1 self reported the incident (fall) to the licensed nurse during the 7:00 am to 3:00 pm nursing shift on April 28, 2025.28 PA. Code 211.10(c)(d) Resident care policies28 PA. Code 211.12(d)(1) Nursing services |

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 - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(continued on next page) |

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| Rehab at Shannondell | 5000 Shannondell Drive<br>Audubon, PA 19403 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record, review of policy and procedures, interviews with staff, and review of hospital records, it was determined that the nursing staff failed to properly supervise one of five residents reviewed during transfer and ambulation. (Resident R1) Findings include:A review of the facility policy titled fall management dated February, 2023 revealed that it was the responsibility of the facility staff to assess residents who were at risk for falls and identify the reason for the fall to prepare a care plan to reduce the potential for future falls. This policy indicated that a plan of care would be developed and initiated to address fall risk factors and measures to prevent falls. A facility incident report will be completed post fall and witness statements/information would be documented and used to develop care plan approaches to prevent falls.A review of the facility's policy titled incident and accident investigation dated January, 2022 revealed that the purpose of the investigation of an incident was to complete a prompt and thorough review and report of all falls to promote resident safety and quality of care. The policy indicated that the registered nurse (ADON-Assistant Director of Nursing) was responsible for the investigation and obtaining employee statements of the circumstances surrounding the fall. The ADON was also responsible for determining new interventions that would be effective to prevent falls. The ADON was also responsible for conducting interviews with the resident involved in the fall. The ADON was responsible for training of tasks to staff to prevent further falls. The ADON was responsible for providing a summary of the investigation into the fall/incident. Review of Resident R1's clinical record revealed that the resident was admitted to the facility on [DATE] with the diagnosis of Anemia, Atrial Fibrillation (irregular heart beat) and generalized weakness. Review of physical therapist's assessment dated [DATE] indicated Resident R1 had a diagnosis of BPPV (vertigo or sudden onset of asensation of spinning or moving). The therapist's assessment also indicated that Resident R1 had kyphosis (an excessive forward curve of the spine) and inadequate hip extension, unsteadiness on the feet and inadequate toe clearance; which was associated with muscle weakness in the resident's gait. The therapist assessed Resident R1 to be at risk for falls; because of the resident reduced balance. The physical therapy care plan for Resident R1 was to provide Resident R1 with partial/moderate assistance with walking to prevent falls. Review of the occupational therapist assessment dated [DATE] indicated Resident R1 required care giver assist to walk with cues from staff to perform proper/safe walking techniques for a distance of 15 feet with a roller walker. The occupational therapist indicated that Resident R1 required the support of a staff member to stand from a seated position.Clinical record review revealed a physicial therapy progress note dated April 24, 2025 that indicated Resident R1 had decreased cadence (balance or movement), decreased step/stride length and decreased toe clearance and flexed posture. The progress indicated that Resident R1 was ambulating with a roller walker and care giver assist with a wheelchair following. Review of Resident R1's admission comprehensive assessment (MDS-an assessment of care needs) dated April 28, 2025 indicated that this resident was cognitively intact. Resident R1 was assessed with bilateral lower extremity impairments on both sides of the body. The assessment indicated for toileting hygiene Resident R1 required supervision or touching assistance in which the staff provides verbal cues and/or touching and/or contact guard assistance as resident completes the activity. The resident had functional mobility impairments from chair/bed to chair transfers; required supervision or touching assistance provided by staff. Resident R1 required partial/moderate assistance from staff for ambulation. The staff member was required to lifted, hold or support the trunk or limbs of the resident for ambulation or transfers. The resident was dependent for walking 50 feet with assist of two for ambulation 50 feet. The comprehensive assessment identified Resident R1 as occasionally incontinent of urine. Review of Resident R1's care plan dated April 22, 2025 revealed that the resident was care planned for falls. Interventions included to assist with transfers as needed and resident is supervision.Review for Resident R1's nursing notes dated April 24, 2025 at 10:25 a.m. indicated This nurse was called by therapy and was notified that this patient had fallen with therapy out of the balcony. This nurse went to the balcony right away. The patient was found lying face down with her head towards the ceiling. She was immediately assessed for injuries by this nurse .This nurse notice bleeding form her right hand and right knee .CRNP noticed. Continued review of nursing notes dated April 24, 2025 at 11:04 a.m. revealed that the resident reported discomfort of bilateral knees and left side. Nursing note dated April 25, 2025 indicated that continued care from the occupational and physical therapy departments were necessary for gait training, transfer training and dynamic balance to help prevent further |