STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396143	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER: Aristacare at East Falls		STREET ADDRESS, CITY, STATE, ZIP CODE: 3300 Henry Avenue, 7th Floor Philadelphia, PA 19129	

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508 Based on observation, review of clinical records and facility policies and interviews with staff, it was determined that the facility failed to timely assess, monitor and provide treatment consistent with professional standards to Resident R1's sacral pressure ulcer. This failure resulted in actual harm to Resident R1 who experienced a delay in treatment and healing to a sacral pressure ulcer for one of two residents reviewed for pressure ulcer. (Resident R1) Findings include: Review the facility policy on Pressure Ulcer Treatment revealed that under section Purpose stated that the purpose of this procedure is to provide guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcers. Under section General Guidelines #1. The pressure ulcer treatment program should focus on the following strategies, a. Assessing the resident and the pressure ulcers. b. Managing tissue loads. c. Pressure Ulcer care e. Operative repair of the pressure ulcer. f. Education and quality improvement. #2. When an eschar is present, a pressure ulcer cannot be accurately staged until the eschar is removed. Review of Resident R1's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses of Traumatic Subdural Hemorrhage (brain bleed), left hemiplegia/hemiparesis (paralysis/weakness to one side of the body), Muscle Weakness, Reduced Mobility. Review of Resident R1's admission MDS (Minimum Data Set - a federally required resident assessment completed at a specific interval) assessment dated [DATE], Section M0100 (Determination of Pressure Ulcer/Injury Risk) A., revealed that resident has a pressure ulcer, Section M150 (Risk of Pressure Ulcer/Injuries) revealed that Resident R1 was at risk of developing pressure ulcers/injuries. Section M0210 (Unhealed Pressure Ulcer/Injuries) revealed that Resident R1 had one or more unhealed pressure ulcers/injuries. M0300 (Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage) F1 revealed that resident had unstageable pressure ulcer. Review of Resident R1's Nursing Admission assessment dated [DATE], revealed that under section URINARY Resident R1 was incontinent of bladder, Under section SKIN , Resident R1 had an unstageable (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) pressure ulcer on his sacrum. Continued review of the nursing admission assessment did not include the size of the pressure ulcer or any other description of the pressure ulcer. (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 0686

Level of Harm - Actual harm

Residents Affected - Few

Further review of Resident R1's clinical record revealed the following Wound Weekly Observation Tool:

Review of Wound Observation Tool dated July 29, 2024, revealed that Resident R1 had a pressure ulcer on his sacrum. Further the pressure ulcer was coded as Stage 1 (intact skin with a localized area of non-blanchable erythema (redness). Further, wound description as follow: Epithelial tissue (pink) was documented as present with 100% necrosis (black) on wound bed, wound size: 0.2 centimeters (cm) x 0. x 0. 1 cm., peri wound intact.

Wound Weekly Observation Tool dated August 12, 2024, identified a pressure ulcer on his sacrum. Further, the pressure ulcer was coded as Stage 3 (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough (separation of dead tissue from living tissue) and/or eschar (dark, crusty tissue covering the wound) may be visible but does not obscure the depth of tissue loss.) Further, wound description as follow: 50% granulation and 50% slough observed, wound size: 2.4 cm. x 3.0 cm. x 0.1 cm., peri wound intact.

Wound Weekly Observation tool dated August 19, 2024, revealed that Resident R1 had a pressure ulcer on his sacrum. Further, the pressure ulcer was coded as Stage 3. Wound description as follow: epithelial tissue, granulation and slough present, wound size: 2.5 cm. x 3.0 cm. x 0.1cm, peri wound intact.

Wound Weekly Observation tool dated August 27, 2024, revealed that Resident R1 had a pressure ulcer on his sacrum. Further, the pressure ulcer was coded as Stage 3. Wound description as follow: epithelial tissue, granulation and slough present, wound size: 3.0 cm. x 3.1 cm. x 0.1cm., peri wound intact.

Wound Weekly Observation tool dated September 3, 2024, revealed that Resident R1 had a pressure ulcer on his sacrum. Further. the pressure ulcer was coded as Stage 3. Wound description as follow: epithelial tissue, granulation and slough present, wound size: 4.4 cm. x 3.1cm. x 0.1cm., peri wound intact.

Wound Weekly Observation tool dated September 14, 2024, revealed that Resident R1 had a pressure ulcer on his sacrum. Further, the pressure ulcer was coded as Stage 3. Wound size was 6.0 cm. x 4.0 cm. x 1.0 c. m, peri wound intact.

Further review of Resident R1's clinical record revealed that Resident R1 was not seen by a wound specialist until September 16, 2024.

Review of wound progress note from the wound specialist dated September 16, 2024, revealed the following: Sacral is an Unstageable Pressure Injury obscured full-thickness skin and tissue loss. Initial wound encounter measurements are 5.5 cm length x 4 cm. width x 0.5 cm depth. No tunneling. No sinus tract. No undermining. Light amount of serous drainage noted with Mild odor. Wound bed has 10%, granulation, 90% eschar: no slough and no epithelialization present.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of wound progress note from the wound specialist dated September 23, 2024, revealed the following: Sacral is an Unstageable Pressure Injury obscured full-thickness skin and tissue loss. Subsequent wound encounter measurements are 6 cm. length x 4 cm. width x 1 cm. depth. No tunneling. No sinus tract. Undermining has been noted at 9:00 and ends at 12:00 with a maximum distance of 1cm. Light amount of serous drainage noted which has a Mild odor. Wound bed has 10%, granulation, 90% slough; no eschar and no epithelialization present. The wound is deteriorating. Further review from the wound specialist note dated September 23, 2024, revealed that sacral pressure ulcer was debrided (removal of damage tissue) with post debridement measurements: 6.1cm length x 4.2cm width x1.3cm depth. Post debridement stage noted as unstageable pressure injury obscured full-thickness skin and tissue loss. Review of physician's orders revealed that there was no treatment order until July 31, 2024, when an order was obtained for Medi honey Wound/Burn Dressing Paste (Wound Dressings) Apply to sacrum topically every dayshift for wound healing. Apply to wound bed after cleansing with NSS (normal saline solution). Cover with dry clean dressing and border gauze. D/C (discontinued) Date- August 19, 2024. Physician's orders dated August 20, 2024, revealed an order for Betadine Solution 10 % (Povidone-Iodine) Apply to sacrum topically every dayshift for wound healing. Apply to wound bad after cleansing with NSS. And cover with dry clean dressing. -D/C Date-August 27, 2024. Physician's order dated August 28, 2024, revealed an order for Hydrogel External Gel (Wound Dressings) Apply to sacrum topically every dayshift for wound healing. Apply to the wound bed after cleansing with NSS and cover with border gauze dressing-D/C Date-September 17, 2024. Physician's order dated September 18, 2024, revealed an order for clean sacral wound with normal saline. Apply Santyl to wound. Cover with clean, dry dressing. Change daily and PRN for soilage/dislodgement. Every dayshift for wound care. Review of physician's progress note dated July 16, 17, 18, 19, 21, 23, 24, 25, 26, 27, 29, 30, 31, 2024, revealed no evidence that Resident R1's wound was seen by the physician. Review of Resident R1's care plan revealed that there was no wound care plan until August 22, 2024, when Resident R1's care plan for actual impairment to the sacrum was initiated. Review of Nurse's Aides Task from July 15, 2024 to October 15, 2024, in resident's clinical record revealed no documented evidence that resident was turned and positioned. Interview with Director of Nursing Employee E2 conducted in October 16, 2024 at 11:46 a.m. confirmed that there was no documented evidence that the turning and positioning was conducted as a measure to prevent further deterioration in Resident R1's pressure ulcer. Further, Employee E2 revealed that she was not yet employed at the facility in July and August of 2024. Wound observation conducted on October 16, 2024, at 10:10 a.m. with licensed Practical Nurse (LPN) Employee E3 and Nurse Aide, Employee E4, revealed that Resident R1 had a sacral pressure ulcer. Further observation revealed that the wound bed appeared beefy red in color. Measurements were not taken at the time of observation. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview with Employee E3 conducted at the time of the observation revealed that Resident R1's pressure ulcer was a Stage 4 (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer). Review of Resident R1's clinical record revealed that there was no documented evidence that Resident R1's sacral pressure ulcer was monitored and assessed after it was identified on admission on July 15, 2025. It was not until July 29, 2024, when a wound weekly Observation Tool was performed. There was no documented evidence that a plan of care was developed with interventions precautions to improve or prevent further deterioration of Resident R1's sacral pressure ulcer upon admission to the facility on [DATE]. Further review of Resident R1's clinical record revealed no documented evidence that wound treatment was initiated upon the identification of Resident R1's sacral pressure ulcer on July 15, 2024, until July 31, 2024. The facility failed to assess, monitor and provide timely treatment to Resident R1's unstageable pressure ulcer identified at admision resulting in actual harm to Resident's R1 who experienced a delay in treatment and healing to a sacral pressure ulcer. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing Services.