STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396143	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at East Falls	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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, interviews with staff and hospital staff, reviews of hospital records, electronic communication records and facility policies and procedures, it was determined that the facility failed to permit one of one resident's reviewed to return to the facility after hospitalization. (Resident R10) Findings include: Review of the undated policy titled Holding Bed Space revealed that AristaCare at East Falls shall inform residents upon admission and at a transfer for hospitalization or therapeutic leave of our bed-hold policy. Upon admission and when a resident is transferred for hospitalization or for therapeutic leave, a representative of the building will provide information concerning our bed-hold policy. 2. When emergency transfers are necessary, AristaCare at East Falls will provide the resident or representative (sponsor) with information concerning our bed-hold policy of such transfer. 3. The bed-hold information will include any charges that the resident may incur as well as the time limit established by the State Medicaid Plan for which, AristaCare at East Falls reserve the resident's bed-space. (Note: Reissuance of the admission notice will be made if the bed-hold policy under the State Medicaid Plan or the facility's policy changes.) 4. The maximum number of days that our State Medicaid Plan has a hold on a Medicaid resident's bed is fifteen (15) days per hospitalization. 5. Bed-hold days in excess of our State Medicaid Plan are considered non-covered services. A resident will be required to pay for any additional days that he/she wishes, AristaCare at East Falls to hold the bed. 6. Medicaid residents whose bed-hold days have expired and have chosen not to pay privately will be offered the next available appropriate bed. 7. Ma(Medicaid) pending residents, the facility treat as MA approved for the 15 day bed hold period. After that time the resident will follow the Non-Medicaid resident process. 8. Non-Medicaid residents will be required to provide, AristaCare at East Falls with authorization to reserve the bed within twenty-four (24) hours of the resident's transfer from the facility. 9. A Medicaid resident who elects not to pay for non-covered services and whose hospitalization or therapeutic leave exceeds the bed-hold period established by the State Medicaid Plan will be readmitted when a clinically appropriate bed in a semi-private room becomes available. Clinical record review for Resident R10 revealed that this resident was admitted from the hospital on [DATE], with diagnoses to include acute and chronic respiratory failure and tracheostomy (a surgical procedure where an opening (stoma) is created in the windpipe (trachea) in the neck to allow for breathing) status. Review of clinical record revealed that the payor source for Resident R10's stay at the facility was documented as Medicaid pending (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing note dated February 22, 2025, indicated, that the resident was transferred to hospital for abnormal labs(low hemoglobin blood level). Continued review of the nursing note dated February 22, 2025, indicated, that the resident was admitted to the hospital with sepsis(a life-threatening medical emergency that occurs when the body's response to an infection harms its own tissues and organs). Review of MDS for Resident R10 revealed that the resident was discharged and return to the facility was anticipated. Review of the clinical record from February 22 to [DATE], revealed no evidence that the facility inquired about Resident R10, discharge plan or return status. Interview with Case Management staff at the hospital on [DATE], at 1:58 p.m. stated that the facility denied residents readmission to the facility. She stated resident stayed in the hospital to finish an antibiotic treatment which was expensive. After her antibiotic treatment from March first week to till May she has reached out to the facility numerous times to let the facility know that the resident was ready to return to the facility. Case Management staff stated facility told her that the facility won't readmit the resident if the resident/representative don't handover the financial statements. Interview with the Director of Nursing on [DATE], at 4:43 p.m. stated the resident was transferred to the hospital for medical reason. Interview with the facility Liaison, Employee E7, who work for resident referrals from the hospital on [DATE], at 12:21 p.m. stated she told the hospital case manager that she would accept the resident when the financial information. Employee E7 confirmed that the financial information was a condition for resident's readmission even though the resident was sent out for medical reason. Review of text message communication between the hospital case manager and Employee E7 revealed that on [DATE], asked about Resident R10's return to the facility, however Employee E7 stated that the facility don't have any open beds. On [DATE] similar conversation happened for resident to return but no response was provided. On [DATE], inquired about an available bed for Resident R10 but Employee E7 stated no beds were available. Hospital also inquired about beds availability for Resident R10 to readmit to the facility on on [DATE], 18 and [DATE], Review of hospital records from [DATE], to [DATE], revealed that the hospital faxed clinical record for Resident R10 numerous times to transfer the resident back to the facility. However, facility did not review the record or accepted the resident. Review of facility selected facility census on [DATE], 13, [DATE], 24, 25, 27, [DATE], 5, 2025, revealed that the facility had open beds for Resident R10. Interview with the Administrator on [DATE], confirmed that the facility needed financial information prior to resident's admission to the facility. Administrator confirmed that the facility put financial information as a condition for Resident R10 to readmit to the facility. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 PA. Code 201.14(a)(b) Responsibility of licensee 28 PA. Code 201.29(c.3)(4) Resident rights 28 PA. Code 211.12(d)(1) Nursing services

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of clinical records, facility policies, review of professional standard of practice, observations, and interview with staff, it was determined the facility failed to provide treatment as ordered by the physician, to prevent pressure ulcers. This failure resulted in Immediate Jeopardy situation for Resident R2, Resident R3 and Resident R8 who developed pressure ulcers. The facility failed to provide treatment and services consistent with professional standards of practice to promote healing and prevent infection of existing pressure ulcers. This failure resulted in actual harm to R1, R2, R3, R4, R5, R6, R7, and R8 whose pressure ulcers worsened and/or deteriorated for eight of nine residents reviewed. (Residents R1, R2, R3, R4, R5, R6, R7, and R8) Findings Include: Review of US Department of Health and Human Services, Agency for Healthcare Research & Quality, revealed the pressure ulcer best practice incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, standardized pressure ulcer risk assessment, and care planning and implementation to address the areas of risk. Review of the American College of Physicians (ACP) national organization of internists who specialize in the diagnosis, treatment, and care of adults revealed Clinical Practice Guidelines indicating the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i.e., support surfaces, repositioning, and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement, and wound cleansing; using adjunctive therapies; and considering possible surgical repair. Review of an undated facility policy Prevention of Pressure Ulcers, revealed the following: GENERAL GUIDELINES 1 The most common site of a pressure ulcer is where the bone is near the surface of the body including the back of the head around the ears, elbows, shoulder blades, backbone, hips, knees, heels, ankles, and toes. 2. Pressure can also come from splints, casts, bandages, and wrinkles in the bed linen. If pressure ulcers are not treated when discovered, they quickly get larger, become very painful for the resident, and often times become infected. 3. Pressure ulcers are often made worse by continual pressure, heat, moisture, irritating substances on the resident's skin (i.e. perspiration, feces, urine, wound discharge, soap residue, etc.), decline in nutrition and hydration status, acute illness and/or decline in the resident's physical and/or mental condition. 4. Once a pressure ulcer develops, it can be extremely difficult to heal. Pressure ulcers are a serious skin condition for the resident. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	5. Assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family, and addressed. 6. Once identified, the wound NP (Nurse Practitioner)/Physician is notified about the consult by DON (Director of Nursing)/designee. 6. Skin checks weekly are suggested. If done, document. INTERVENTIONS AND PREVENTIVE MEASURES: GENERAL General Preventive Measures 1. Identify risk factors for pressure ulcer development (see procedure entitled Pressure Ulcer Risk Assessment). 2. For a person in bed. a. Change position at least every two hours or more frequently if needed b. Determine if resident needs a special mattress c. If a special mattress is needed, use one that contains foam, air, gel, or water, as indicated d. Raise the head of the bed as little and for as short a time as possible, and only as necessary for meals, treatments and medical necessity. 3. For a person in a chair: a. Change position at least every hour b. Use foam, gel, or air cushion as indicated to relieve pressure. 4. When repositioning, reduce friction and shear by lifting (using appropriate lifting technique and equipment) rather than dragging. 5. Do not use donut-shaped cushions. 6. Refer resident to a rehabilitation program, or a restorative nursing program, as indicated. 7. Encourage the resident to participate in active and passive range of motion exercises to improve circulation. 8. Ensure that the resident drinks plenty of fluids and eats a well-balanced diet. 9. Routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown. 10. Immediately report any signs of a developing pressure ulcer to the supervisor. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	11. The care process should include efforts to stabilize, reduce or remove underlying risk factors; to monitor the impact of the interventions; and to modify the interventions as appropriate. Risk Factor - Bed-fast: a. Change position at least every two hours and more frequently as needed. b. Use a special mattress that contains foam, air, gel, or water, as indicated. c. Raise the head of the bed as little and for as short a time as possible, and only as necessary for meals, treatments and medical necessity. d. Consider off-loading pressure hourly if the head of the bed is greater than 30 degrees (e.g., for residents with tube feeding or respiratory issues). e. Unless resident has both sacral and ischial pressure ulcers, avoid placing directly on the greater trochanter for more than momentary placement. Review of an undated facility policy revealed the following: Pressure Ulcer Treatment 1. The pressure ulcer treatment program should focus on the following strategies: a. Assessing the resident and the pressure ulcer(s). b. Managing tissue loads. c. Pressure ulcer care. d. Managing bacterial colonization and infection. e. Operative repair of the pressure ulcers(s). f. Education and quality improvement. Pressure ulcer treatment requires a comprehensive approach, including: 1. Debridement (removal of dead, damaged, or infected tissue to improve the healing potential of the remaining healthy tissue). 2. Managing infections. 3. Managing systemic issues (edema (swelling), venous insufficiency, etc). 4. Maximizing the potential for healing. 5. Pain control. 6. All wounds are to be seen weekly by wound Nurse Practitioner/Wound Nurse (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	7. All strategies for treatment are individualized. Stage II (ulcer involving loss of the top layers on the skin) Pressure Ulcer Interventions/Care Strategies Clean, shallow, minimal drainage: 1. Protect 2. Manage drainage 3. Promote moist wound healing 4. Treatment: a. Cleanse with normal saline or other skin cleanser in accordance with physician orders and facility protocol b. Apply barrier cream, or tx (treatment) c. Cover with non-adhesive light gauze or transparent dressing d. Change per physician order and manufacturer's directions. 5. Manage pain. Medium drainage: 1. Follow above procedure; consider the need for alginate or foam. Follow-up If wound does not improve in 2-3 weeks, notify physician. Consider a skin consult with a wound specialist. STAGE III (ulcer involving full thickness of skin loss, exposing tissue) PROTOCOL Stage III Pressure Ulcer Interventions/Care Strategies 1. Protect 2. Fill dead space including tunnels and undermining 3. Manage drainage 4. Promote moist wound healing 5. Manage pain (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	No drainage: 1. Treatment a. Irrigate wound with normal saline (NS) or other designated wound cleanser or use circular motion for cleaning from inside of wound to outer edges with NS soaked gauze. b. Apply tx to wound cavity c. Change per order and manufacturer's directions. d. Manage pain Medium to heavy drainage: 1. Follow above procedure. Consider substituting alginate or foam. STAGE IV (ulcer involving loss of skin layers, exposing muscle and bone) PROTOCOL Stage IV Pressure Ulcer Interventions/Care Strategies 1. Protect: a. Fill dead space including tunnels and undermining b. Manage drainage c. Promote moist wound healing. 2. Debride slough/eschar (hardened, dry, black or brown dead tissue, forms a scab-like covering over deep wounds. It acts as a protective barrier but can impede healing) a. Select the method of debridement most appropriate to the resident's condition and goals (note: this is a physician task/NP task) b. Sharp, mechanical, enzymatic, and/or autolytic (breaking down of cells or tissues by their own enzymes) debridement techniques may be used when there is no urgent clinical need for drainage or removal of devitalized tissue c. If there is urgent need for debridement, as with advancing cellulitis or sepsis (potentially life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs), sharp debridement should be used. 3. Treatment: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	a. Irrigate wound with normal saline or other designated wound cleanser or use circular motion for cleaning from inside of wound to outer edges with NS soaked gauze. b. Apply treatment c. Cover with DSD (Dakin's solution) Review of clinical record for Resident R1 revealed Resident R1 was admitted to the facility on [DATE], with diagnoses including Anoxic Brain Damage (the brain is completely deprived of oxygen, leading to potential brain cell death) and Tracheostomy (surgical procedure where an opening is made in the neck to access the trachea) status. Review of Resident R1's physician orders dated March 18, 2025, revealed an order to turn and reposition every 2 hours - Nurse Aide to document the completion every shift in Nurse Aide charting. Further review of Resident R1's physician orders revealed the resident had a wound care order for sacral wound with calcium alginate and Medi honey and cover with border dressing. Review of Resident R1's Braden Scale (tool used to assess a patient's risk of developing pressure ulcers) assessment for Resident R1 dated March 19, 2025, revealed Resident R1 was at very high risk for developing pressure injuries. Review of skin assessment for Resident R1 dated March 19, 2025, revealed the resident had a skin tear to the sacrum which measured 4 x 0.5 with no depth. (No unit of measurement was included) Review of an admission MDS for Resident R1 (Minimum Data Set- periodic assessment of resident care needs) dated March 23, 2025, revealed that the resident did not have a pressure injury. Review of re-admission nursing note for Resident R1 dated March 27, 2025, revealed the resident had a wound on the sacrum, however, further review of nursing note failed to specify type, measurement, or any other wound characteristics. Review of Braden Scale assessment for Resident R1 dated March 27, 2025, following readmission revealed the resident was at very high risk for developing pressure injuries. Review of skin assessment for Resident R1 dated March 27, 2025, failed to identify if the resident had any wounds including the measurements. Review of an admission MDS (Minimum Data Set-Assessment of resident care needs) for Resident R1 dated April 3, 2025, revealed the resident was not able to complete BIMS (Brief Interview of Mental Status) assessment which indicated that the cognitive status for the resident was severely impaired. Further review of the MDS assessment revealed the resident was dependent (helper does all of the effort. Resident does none of the effort to complete the activity or, the assistance of two or more helpers is required for the resident to complete the activity) on staff for all ADLs (activities of Daily Living) including bed mobility. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Additional review of Resident R1's MDS assessment revealed the resident was always incontinent of bowel and bladder. Continued review of MDS assessment revealed the resident had an unstageable pressure injury and was at risk for developing pressure ulcers. It was also revealed the resident was receiving tracheostomy/ventilator treatment. Review of wound care practitioner progress note for Resident R1 dated April 1, 2025, revealed Significant contributors for increased risk of wound incidence and/or impede healing include but not limited to vascular complicating factors, generalized muscle weakness, impaired mobility, and inevitable effects of aging. Education provided regarding pressure relief, general offloading, and frequent repositioning. Wound measurement was 6 cm (centimeters) length x 5cm width x 1 cm depth with an area of volume of 30 cubic cm. Additional review of the wound care practitioner's note dated April 1, 2025 for Resident R1 revealed a recommendation for wound care with Dakin's wound care solution. There were additional orders for off-loading, facility Pressure Injury Prevention Protocol, Pressure Redistribution Mattress per Facility Protocol, Wheelchair Pressure Redistribution Cushion per Facility Protocol and Offload heels per Facility Protocol. Review of April 2025's physician orders and April 2025's Treatment Administration Record (TAR) for Resident R1 failed to reveal documented evidence of an air mattress provided as recommended by the physician. Further review of April 2025 TAR revealed the resident received wound care treatment with Dakin's and there was treatment which was signed out as completed for Calcium Alginate and Medi honey and cover with border dressing. It was unclear which treatment the resident received. Interview with the Director of Nursing on May 2, 2025, at 1:00 p.m. confirmed the resident had two different orders for wound care and signed as administered, however the Director of Nursing was not able to specify which treatment the resident received. Review of wound care practitioner's note dated April 8, 2025, revealed that wound measurement was 5 cm length x 6 cm width x 2 cm depth with an area of volume of 60 cubic cm. The wound was staged as Stage 4 (ulcer involving full thickness of skin layers, exposing muscle and bone) pressure injury. There was also moderate amount of serosanguineous (type of wound drainage composed of blood serum and red blood cells) drainage. Further review of the wound care practitioner's note revealed a recommendation for wound care with Dakin's wound care solution, cover with alginate (highly absorbent, conformable, and fast-gelling dressings derived from seaweed, and are used to manage moderate to heavily exuding wounds) and border gauze daily and as needed. Continued review revealed additional orders for off-loading, facility Pressure Injury Prevention Protocol, pressure redistribution mattress per facility protocol, wheelchair pressure redistribution cushion per facility protocol and offload heels per facility protocol. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of wound care practitioner's note dated April 15, 2025, revealed wound measurement was 5 cm length x 6 cm width x 3 cm depth with an area of volume of 90 cubic cm. The wound was staged as Stage 4 (ulcer involving loss of skin layers, exposing muscle and bone) pressure injury. There was also moderate amount of serosanguineous drainage. Further review of the wound care practitioner progress note revealed a recommendation for wound care with Dakin's wound care solution, cover with Alginate and border gauze daily and as needed. Review of wound care practitioner progress note dated April 22, 2025, revealed the wound measurement was 7 cm length x 6 cm width x 3 cm depth with an area of volume of 126 cubic cm. Undermining (condition where the tissue beneath the edges of a wound separates from the underlying structures, creating a cavity or pocket) has been noted at 12:00 and ends at 12:00 with a maximum distance of 4 cm. The wound was staged as Stage 4 pressure injury. Further review of the wound care practitioner progress note revealed a recommendation for wound care with Dakin's wound care solution, cover with Alginate and border gauze daily and as needed. Review of Resident R1's April 2025 TAR (Treatment Administration record) revealed Resident R1 received wound care treatment with Dakin's however Alginate was not added to the wound care order as instructed by the physican. Review of care plan of March 18, 2025 for Resident R1 failed to reveal a turning and repositioning intervention, air mattress or other off-loading measures. The only interventions noted were dietary consult and monitoring of skin injury. Interview with the Wound Care Practitioner, Employee E3, on May 6, 2025, at 11:34 a.m. revealed wound care with Calcium Alginate was prescribed for Resident R1 who had wound drainage. When Calcium Alginate is prescribed it was important to provide the wound care with Calcium Alginate to minimize the chances of infection and prevent the deterioration of wound. Employee E3 revealed he was not aware of the resident not receiving the ordered prescribed. Review of Resident R1's clinical record revealed the initial wound care order placed on April 1, 2025, was not changed by the facility as recommended by the wound care practitioner. Facility continued the same wound care, which was ordered on March 20, 2025, for the same wound. Review of Resident R1's clinical record and facility documentation failed to reveal evidence of turning and repositioning, pressure reducing devices including air mattress were provided as ordered by the physician. These failures resulted in worsening/deterioration of pressure ulcers for Resident R1 whose wound size increased from 4 x 0.5 with no depth on March 19, 2025, to 6 cm length x 5cm width x 1 cm depth with an area of volume of 30 cubic cm on April 23, 2025. The wound further deteriorated to 7 cm length x 6 cm width x 3 cm depth with an area of volume of 126 cubic cm. Review of clinical record for Resident R3 revealed that resident was admitted to the facility on [DATE], with diagnoses including anoxic brain damage (occurs when the brain is completely deprived of oxygen, leading to potential brain cell death) and tracheostomy (a surgical procedure where an opening is made in the neck to access the trachea) status. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of quaterly MDS (Minimum Data Set-Assessment of resident care needs) for Resident R3 dated February 21, 2025, revealed that the resident was not able to complete BIMS (Brief Interview of Mental Status) assessment which indicated that the cognitive status for the resident was severely impaired. Further review of the MDS revealed that the resident was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) on staff for all ADLs (Activities of Daily Living) including bed mobility. MDS also revealed that the resident was always incontinent of bowel and bladder. Continued review of MDS assessment revealed the resident had an unstageable pressure injury and was at risk for developing pressure ulcers. The assessment further revealed the resident was receiving tracheostomy/ventilator treatment. The assessment documented the resident had one Stage 4 unhealed pressure ulcer at the time of assessment which was documented as present on admission. Review of Braden Scale (tool used to assess a patient's risk of developing pressure ulcers) assessment for Resident R3 dated September 26, 2024, revealed that the resident was at very high risk for developing pressure injuries. Review of skin assessment for Resident R3 dated March 24, 2025, revealed that the resident had no skin impairment. Review of skin assessment for Resident R3 dated March 27, 2025, revealed that the resident had skin impairment to sacrum and left toe. There was no type, measurement or other wound characteristics specified on the skin assessment report. Review of wound care practitioner's note for Resident R3 dated March 25, 2025, revealed that the resident had a total of three (3) wounds one of which was a sacral pressure injury which measured 2cm length x 1.8 cm width x 1 cm depth, with an area volume of 3.6 cubic cm. The wound had no tunneling or undermining. The wound was staged as Stage 4. The two other wounds were non-pressure injury related wounds. Further review of the wound care practitioner's note for Resident R3 revealed a recommendation for wound care with collagen, moistened gauze with normal saline and cover with dry dressing. There were additional orders for off-loading, facility Pressure Injury Prevention Protocol, pressure redistribution mattress per facility protocol, avoid direct pressure to wound site, protocol and offload heels per facility protocol. Review of March 2025 TAR, revealed no documented evidence that the facility provided air-mattress for Resident R3 as ordered by the physician. Review of wound care practitioner's note for Resident R3 dated April 1, 2025, revealed that the resident developed a new unstageable wound to the right ischial tuberosity (protuberance of a bone) which measured 1.0 cm x1. 0 cm x 0.1 cm. with an area of volume of 0.1 cm. The sacral pressure injury which measured 2cm length x 1.7 cm width x 1 cm depth, with an area volume of 3.6 cubic cm. Further review of the wound care practitioner's note for Resident R3 revealed a recommendation for sacral wound care with Alginate and cover with dry dressing. The right ischial tuberosity wound care with honey gel and cover with border gauze. There were additional orders for off-loading, facility Pressure Injury Prevention Protocol, pressure redistribution mattress per facility protocol, avoid direct pressure to wound site, protocol and offload heels per facility protocol. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of Resident R3's April 2025 TAR failed to reveal documented evidence the facility provided an air-mattress for Resident R3 as ordered by the physician. Review of wound care practitioner's note for Resident R3 dated April 8, 2025, revealed that the resident developed another new stage 2 (partial thickness skin loss) wound to the left buttocks which measured 2.0 cm x 2.0 cm x 0.1 cm. with an area of volume of 0.4 cm. The right ischial tuberosity which measured 3.0 cm x 3.0 cm x 0.1 cm. with an area of volume of 0.9 cm. The sacral pressure injury which measured 2 cm length x 1.7 cm width x 1 cm depth, with an area volume of 3.4 cubic cm. Review of wound care practitioner's note for Resident R3 dated April 15, 2025, revealed that the left buttocks wound measured 5.0 cm x 2.5 cm x 0.1 cm. with an area of volume of 1.25 cm. The right ischial tuberosity which measured 3.0 cm x 5.5 cm x 0.1 cm. with an area of volume of 0.9 cm. The sacral pressure injury which measured 2cm length x 2 cm width x 1 cm depth, with an area volume of 4 cubic cm. Further review of the wound care practitioner's note for Resident R3 dated April 15, 2025, revealed a recommendation for sacral wound care with Alginate and cover with dry dressing. The right ischial tuberosity wound care with honey gel, apply Alginate and cover with border gauze. The left buttock wound care with honey gel, apply Alginate and cover with border gauze. Additional review of wound care practitioner's note dated April 15, 2025 revealed additional orders for off-loading, facility Pressure Injury Prevention Protocol, pressure redistribution mattress per facility protocol, avoid direct pressure to wound site, protocol and offload heels per facility protocol. Review of Resident R3's April 2025 TAR failed to reveal documented evidence wound treatment was provided to left buttock wound for the month of April 2025. The right ischial wound care was not changed as recommended by the wound care practitioner. Review of wound care practitioner's note for Resident R3 dated April 22, 2025, revealed that the left buttocks wound measured 5.0 cm x 2.6 cm x 0.1 cm. with an area of volume of 1.3 cm. This wound was re-staged as Stage 3 (full thickness skin loss) pressure ulcer. The right ischial tuberosity which measured 8.0 cm x 8 cm x 0.2 cm. with an area of volume of 12.8 cm. The sacral pressure injury which measured 2.1 cm length x 2 cm width x 1 cm depth, with an area volume of 4.2 cubic cm. Further review of the wound care practitioner's notes for Resident R3 revealed a recommendation for sacral wound care with Alginate and cover with dry dressing. The right ischial tuberosity (bony prominence in the pelvis that serves as a key weight-bearing structure when sitting) wound care with Santyl, cover with Dakin's moistened gauze cover with border gauze. The practitioner documented the reason for change as Right ischial unstageable increased in size and eschar. Will change treatment to Santyl with 1/4 Dakin's moistened gauze and cover with border gauze daily. The left buttock wound care consisted of honey gel, apply alginate and cover with border gauze. Review of Resident R3's April 2025 TAR failed to reveal documented evidence treatment was provided to left buttock wound. The right ischial wound care was not changed as recommended by the practitioner. The recommended wound care in response to the wound deterioration was not implemented for the right ischial wound. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of wound care practitioner's note for Resident R3 dated April 22, 2025, revealed that Right ischial unstageable increased in size and odor. Recommend x-ray of right ischium and hip to rule out Osteomyelitis (bone infection). No surrounding erythema (swelling), induration or purulence. Will continue with Santyl and 1/4 Dakin's moistened gauze and cover with border gauze daily and as needed, wound with high risk for worsening and infection due to critical care condition, immobility, impaired cognition, comorbid conditions. Continued review revealed that the left buttocks wound measured 5.0 cm x 3.0 cm x 0.1 cm. with an area of volume of 1.5 cm. The right ischial tuberosity which measured 10.0 cm x 10 cm x 0.5 cm. with an area of volume of 50 cubic cm. There was also light amount of sero-sanguineous drainage with 80% eschar and 20% slough. The sacral pressure injury which measured 2.2 cm length x 2 cm width x 1 cm depth, with an area volume of 4.4 cubic cm. Review of Resident R3's clinical record and facility documentation revealed the facility did not provide wound care recommended by the wound care practitioner on April 15, 2025, April 22, 2025, and April 29, 2025 for right ischium wound. Facility documentation lacked evidence that air mattress were provided as ordered by the physician. These failures resulted in development and worsening/deterioration of the right ischium pressure ulcers for Resident R3 whose wound size increased from 3.0 cm x 5.5 cm x 0.1 cm. with an area of volume of 0.9 cubic cm on April 15, 2025, to 10.0 cm x 10 cm x 0.5 cm. with an area of volume of 50 cubic cm with light amount of sero-sanguineous drainage with 80% eschar and 20% slough. on April 29, 2025. It was also revealed that the facility did not provide wound care recommended by the wound care practitioner on April 8, 2025, April 15, 2025, April 22, 2025, and April 29, 2025, for left buttocks wound. Facility documentation lacked evidence an air mattress was provided as ordered by the physician. These failures resulted in the development and worsening/deterioration of the left buttock pressure ulcer wounds for Resident R3, who developed the wound and the wound size increased from 2.0 cm x 2.0 cm x 0.1 cm. with an area of volume of 0.4 cm. on April 8, 2025, to 5.0 cm x 3.0 cm x 0.1 cm. with an area of volume of 1.5 cm on April 29, 2025. Resident's wound deteriorated from Stage 2 to 3. Review of clinical record for Resident R2 revealed that resident was admitted to the facility on [DATE], with diagnoses including Anoxic Brain damage (occurs when the brain is completely deprived of oxygen, leading to potential brain cell death) and Tracheostomy (surgical procedure where an opening is made in the neck to access the trachea) status. Review of Resident R2's admission MDS January 27, 2025 revealed that the resident was not able to complete BIMS assessment which indicated that the cognitive status for the resident was severely impaired. Further review of the MDS assessment revealed the resident was dependent on staff for all ADL activities including bed mobility. The MDS assessment further revealed the resident was always incontinent of bowel and bladder. Continued review of MDS revealed the resident had an unstageable pressure injury and was at risk for developing pressure ulcers. It was also revealed that the resident was receiving tracheostomy/ventilator treatment. It was documented as the resident had one Stage 4 unhealed pressure ulcer at the time of assessment which was documented as present on admission. Review of Braden Scale assessment for Resident R2 dated March 11, 2025, revealed the resident was at very high risk for developing pressure injuries. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the physician order for Resident R2 dated March 12, 2025, revealed an order for Prevalon boot (devise use to help prevent pressure ulcers) when in bed. Review of wound care practitioner note for Resident R2 dated March 18, 2025, revealed that the resident had a sacral pressure injury which measured 6 cm length x 5 cm width x 3 cm depth, with an area volume of 90 cubic cm. Further review of the wound care practitioner notes for Resident R2 revealed a recommendation for sacral wound care with Vashe moistened rolled gauze and cover with border dressing. There were additional orders for off-loading, facility Pressure Injury Prevention Protocol, pressure redistribution mattress per facility protocol, wheel chair pressure redistribution cushion, and offload heels per facility protocol. Review of March 2025 TAR, revealed no documented evidence that the facility provided air-mattress for Resident R2 as ordered by the physician. Observation of the Resident R2 on May 2, 2025, at 12:00 p.m. revealed that the resident was lying flat in the bed, resident was not an air mattress. It was observed that the resident's heel was lying flat on the bed without any offloading measures. This observation was confirmed by the Wound Care Nurse, Employee E4. Review of wound care practitioner note for Resident R2 dated March 25, 2025, revealed that the sacral pressure injury which measured 6 cm length x 5 cm width x 3 cm depth, with an area volume of 90 cubic cm. Further review of wound care documentation revealed that the resident developed a heel pressure ulcer on March 24, 2025, which measured 4 cm length x 4 cm width x 0.1 cm depth, with an area volume of 1.6 cubic cm. Review of wound care practitioner note for Resident R2 dated April 1, 2025, revealed that the sacral pressure injury which measured 6 cm length x 5 cm width x 3 cm depth, with an area volume of 90 cubic cm. The heel pressure ulcer measured 3 cm length x 3 cm width x 0.1 cm depth, with an area volume of 0.9 cubic cm. Further review of the wound care practitioner's note for Resident R2 revealed a recommendation for sacral wound care with Vashe moistened rolled gauze and cover with border dressing. Continued review of the wound care practitioner's note for Resident R2 revealed a recommendation for sacral wound care with Vashe moistened rolled gauze and cover with border dressing and Alginate with border gauze for heel ulcer. Review of April 2025 TAR revealed that the heel ulcer was treated with Alginate with medihoney which was not according to the wound care practitioner's recommendation. Review of Nurse Aide Documentation revealed that from April 5, 2025, to May 5, 2025 only 8 shifts out of 240 shifts documented that the offloading of heel was provided. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of wound care practitioner's note for Resident R2 dated April 8, 2025, revealed that the sacral pressure injury which measured 7 cm length x 5 cm width x 3 cm depth, with an area volume of 105 cubic cm. The right heel pressure ulcer measured 3 cm length x 3 cm width x 0.1 cm depth, with an area volume of 0.9 cubic cm. but noted with moderate amount of serosanguinous drainage. New right ischial (hip bone) pressure injury measured 3 x 3 x 0.1 with an area volume of 0.9 cubic cm. Continued review of Resident R2's wound care practit[TRUNCATED]

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on the review of clinical records, facility documentation, interview with staff, it was determined that the facility failed to ensure that nursing staff possessed the appropriate competencies and skill sets related to the care of residents with wounds for one of two employee records reviewed. (Employee E8). Findings Include: Review of clinical records revealed that the facility did not provide treatment and services consistent with professional standards of practice, to prevent pressure ulcers which resulted in the development of pressure ulcer/s for Resident R2, R3 and R8. Review of clinical records also revealed that the facility did not provide treatment and services consistent with professional standards of practice to promote healing and prevent infection which resulted in worsening/deterioration of pressure ulcers for R1, R2, R3, R4, R6, R7, and R8. Interview with the DON, Director of Nursing, on May 6, 2025, at 11:30 a.m. stated facility hired a new wound care nurse Employee E8, in March of 2025, and she was responsible for completing wound rounds with the physician and receive the recommendations and implement the recommendation in resident's clinical records. The wound care nurse was not aware that she should have been changing the orders. A request for wound care competency for Employee E8, was requested to the Director of Nursing on May 6, 2025. Facility did not submit the wound care competency for Employee E8 which was completed prior to the start of the survey on May 2, 2025. 28 Pa. Code: 211.12 (d)(1) Nursing services 28 Pa. Code: 211.12(d)(5) Nursing services

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of job's descriptions, review of facility documentation and interviews with staff, it was determined that the Nursing Home Administrator and Director of Nursing failed to effectively manage the facility to ensure that the facility provides treatment and services consistent with professional standards of practice, to prevent pressure ulcers which resulted in the development of pressure ulcer/s for Resident R2, R3 and R8. The facility failed to provide treatment and services consistent with professional standards of practice to promote healing and prevent infection which resulted in worsening/deterioration of pressure ulcers for R1, R2, R3, R4, R6, R7, and R8. The failure of not properly preventing, managing, and treating pressure injuries placed the residents at the facility at high risk for harm and resulted in an Immediate Jeopardy situation. Findings include: Review of the job description of the Nursing Home Administrator (NHA) revealed that, The primary purpose of your job position is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern long-term care facilities to assure that the highest degree of quality care can be provided to our residents at all times. Ensure that public information (policy manuals, etc.) describing the services provided in the facility is accurate and fully descriptive. Ensure that all employees, residents, visitors, and the general public follow established policies and procedures. Assume the administrative authority, responsibility and accountability of directing the activities and programs of the facility. Ensure that all residents receive care in a manner and in an environment, that maintains or enhances their quality of life without abridging the safety and rights of other residents. Ensure that each resident receives the necessary nursing, medical and psychosocial services to attain and maintain the highest possible mental and physical functional status, as defined by the comprehensive assessment and care plan. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the job description of the Director of Nursing (DON) revealed that, The primary purpose of your job position is to plan, organize, develop and direct the overall operation of our Nursing Service Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be directed by the Administrator and the Medical Director, to ensure that the highest degree of quality care is maintained at all times. Plan, develop, organize, implement, evaluate, and direct the nursing service department, as well as its programs and activities, in accordance with current rules, regulations, and guidelines that govern the long-term care facility. Develop, maintain, and periodically update written policies and procedures that govern the day-to-day functions of the nursing service department. Assist in the development of preliminary and comprehensive assessments of the nursing needs of each resident. Develop a written plan of care (preliminary and comprehensive) for each resident that identifies the problems/needs of the resident, indicates the care to be given, goals to be accomplished, and which professional service is responsible for each element of care. Encourage the resident and his/her family to participate in the development and review of the resident's plan of care. Assist the Resident Assessment/Care Plan Coordinator in the scheduling of care plans and assessments to be presented and discussed at each committee meeting. Ensure that all personnel involved in providing care to the resident are aware of the resident's care plan. Ensure that nursing personnel refer to the resident's care plan prior to administering daily care to the resident. Review nurses' notes to determine if the care plan is being followed. Assist the Resident Assessment/Care Plan Coordinator in planning, scheduling, and revising the MDS, including the implementation of RAPs and Triggers. Review and revise care plans and assessments as necessary, but at least quarterly. Develop and maintain a good rapport with all services involved with the care plan to ensure that a team effort is achieved in developing a comprehensive plan of care. Ensure that medical and nursing care is administered in accordance with the resident's wishes, including the implementation of advance directives. It was revealed that the initial wound care order for Resident R1 placed on April 1, 2025, was not changed by the facility as recommended by the wound care practitioner. Facility also continued the same wound care, which was ordered on March 20, 2025, for the same wound. Facility documentation lacked evidence that turning and repositioning, pressure reducing devices including air mattress were provided as ordered by the physician. These failures resulted in worsening/deterioration of pressure ulcers for Resident R1 whose wound size increased from 4 x 0.5 with no depth on March 19, 2025, to 6 cm length x 5cm width x 1 cm depth with an area of volume of 30 cubic cm on April 23, 2025. The wound further deteriorated to 7 cm length x 6 cm width x 3 cm depth with an area of volume of 126 cubic cm. It was revealed that the facility did not provide wound care for Resident R3 recommended by the wound care practitioner on April 15, 2025, April 22, 2025, and April 29, 2025 for right ischium wound. Facility documentation lacked evidence that air mattress were provided as ordered by the physician. These failures resulted in development and worsening/deterioration the of the right ischium pressure ulcers for Resident R3 whose wound size increased from 3.0 cm x 5.5 cm x 0.1 cm. with an area of volume of 0.9 cubic cm on April 15, 2025, to 10.0 cm x 10 cm x 0.5 cm. with an area of volume of 50 cubic cm with light amount of sero-sanguineous drainage with 80% eschar and 20% slough. on April 29, 2025. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It was also revealed that the facility did not provide wound care recommended by the wound care practitioner on April 8, 2025, April 15, 2025, April 22, 2025, and April 29, 2025, for left buttocks wound. Facility documentation lacked evidence that air mattress was provided as ordered by the physician. These failures resulted in the development and worsening/deterioration the of left buttock pressure ulcers wound for Resident R3, who developed the wound and the wound size increased from 2.0 cm x 2.0 cm x 0.1 cm. with an area of volume of 0.4 cm. on April 8, 2025, to 5.0 cm x 3.0 cm x 0.1 cm. with an area of volume of 1.5 cm on April 29, 2025. Resident's wound deteriorated from Stage 2 to 3. It was revealed that the facility did not provide wound care for Resident R2 recommended by the wound care practitioner on April 8, 2025, April 15, April 22, 2025, and April 29, 2025 for sacral Stage 4 pressure wound. Facility documentation lacked evidence that air mattress were provided as ordered by the physician. Observation also revealed that the resident was not on an air mattress. These failures resulted in the worsening/deterioration the of the sacral pressure ulcers for Resident R2 whose wound size increased from 6 cm length x 5 cm width x 3 cm depth, with an area volume of 90 cubic cm. on March 18, 2025, to 7 cm length x 6 cm width x 3 cm depth, with an area volume of 126 cubic cm. with moderate amount of serosanguineous drainage and 4 cm undermining. on May 6, 2025. It was revealed that the facility did not provide wound care for Resident R2 recommended by the wound care practitioner on March 25, 2025, April 1, 2025, for right heel pressure wound. Facility documentation lacked evidence that air mattress was provided as ordered by the physician and offloading was provided consistently. Observation also revealed that the resident was not on an air mattress and was not wearing recommended heel boots These failures contributed the development of right heel pressure ulcer for Resident R2. It was also revealed that the facility did not provide wound care recommended by the wound care practitioner on April 8, 2025, April 15, April 22, 2025, and April 29, 2025, for right heel pressure wound. Facility documentation lacked evidence that air mattress was provided as ordered by the physician and offloading was provided consistently. Observation also revealed that the resident was not on an air mattress. These failures contributed the development of right ischium pressure ulcer for Resident R2, (Stage 2 measured 3 x 3 x 0.1 with an area volume of 0.9 cubic cm on April 8, 2025, to unstageable which measured 4 x 4 x 0.1 with an area volume of 1.6 cubic cm. and moderate amount of serosanguinous drainage on May 6, 2025). It was revealed that the facility did not provide wound care recommended by the wound care practitioner on April 29, 2025, for sacral unstageable pressure wound. Facility documentation lacked evidence that air mattress was provided as ordered by the physician. Facility documentation revealed no documented evidence that the facility provided turning and repositioning as ordered by the physician. These failures resulted in the worsening/deterioration the of the sacral pressure ulcers for Resident R4 whose wound size increased from 2cm length x 2 cm width x 0.1 cm depth, with an area volume of 0.4 cubic cm. on April 22, 2025, to 6 cm length x 5cm width x 0.1 cm depth, with an area volume of 3 cubic cm. with wound worsening and slough on May 6, 2025. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It was revealed that the facility did not provide wound care recommended by the wound care practitioner on April 29, 2025, for sacral unstageable pressure wound. Facility documentation lacked evidence that air mattress was provided as ordered by the physician. Facility documentation revealed no documented evidence that the facility provided turning and repositioning as ordered by the physician or documented refusals. Facility did not develop and implement a comprehensive care plan for offloading to promote wound healing. These failures resulted in the worsening/deterioration the of the sacral pressure ulcers for Resident R6 whose wound size increased from 3 cm length x 10 cm width x 0.2 cm depth, with an area volume of 3.0 cubic cm. on April 15, 2025, to measured 4 cm length x 6 cm width x 0.2 cm depth, with an area volume of 4. 8 cubic cm. on April 29, 2025. Facility was non-compliant with implementing physician order for Santyl to promote wound healing until May 3, 2025(after the survey was started). It was revealed that the facility did not provide wound care recommended by the wound care practitioner on April 22, 2025 and April 29, 2025, for sacral unstageable pressure wound. Facility documentation lacked evidence that air mattress was provided as ordered by the physician. Facility documentation revealed no documented evidence that the facility provided turning and repositioning as ordered by the physician or documented attempt and refusals. Facility did not develop and implement a comprehensive care plan for offloading to promote wound healing. These failures resulted in the worsening/deterioration the of the sacral pressure ulcers for Resident R7 whose wound size increased from 8 cm length x 5cm width x 0.3 cm depth, with an area volume of 12 cubic cm with moderate amount of sero-sanguineous drainage. On April 22, 2025, to 8 cm length x 8 cm width x 0.2 cm depth, with an area volume of 32 cubic cm with moderate amount of sero-sanguineous drainage and undermining of 1cm. on April 29, 2025. Facility was non-compliant with implementing physician order for Santyl and alginate to promote wound healing until May 3, 2025. It was revealed that the facility did not provide wound care recommended by the wound care practitioner on April 22, 2025 and April 29, 2025, for sacral unstageable pressure wound. Facility documentation lacked evidence that air mattress was provided as per facility pressure ulcer protocol. Facility documentation revealed no documented evidence that the facility provided turning and repositioning as ordered by the physician. Or documented attempt and refusals. Facility did not develop and implement a comprehensive care plan for offloading to promote wound healing. These failures resulted in the worsening/deterioration the of the sacral pressure ulcers for Resident R8 whose wound size increased from 9 cm length x 7 cm width x 0. 1 cm depth, with an area volume of 6.3 cubic cm with moderate amount of sero-sanguineous drainage on April 15, 2025, to 11 cm length x 12 cm width x 0.1 cm depth, with an area volume of 13.2 cubic cm. and wound odor on April 29, 2025. Facility was non-compliant with implementing physician order for Santyl and alginate to promote wound healing. Interview with Director of Nursing (DON) and Administrator on May 6, 2025, at 11:30 a.m. confirmed that Resident R1, R2, R3, R4, R5, R6, R7, and R8 did not receive wound care and pressure ulcer prevention measures according to professional standards of practice and facility wound care guidelines. All the above findings and resident outcome was confirmed by the Director of Nursing. DON stated staff should document turning and repositioning at least every 2 hours, provide and document air mattress in the physician orders, and ensure dietary recommendations for wound healing should be addressed in a timely manner. DON also confirmed that staff should provide wound care treatment based on the orders from wound care practitioner. Continued interview with the DON stated facility hired a new wound care nurse in March of 2025, she was responsible for completing wound rounds with the physician and receive the recommendations and implement the recommendation in resident's clinical records. The wound care nurse was not aware that she should have been changing the orders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396143	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at East Falls	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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DON also confirmed that care plans for Resident R1, R2, R3, R4, R5, R6, R7, and R8 did not have turning and reposition interventions, air mattress or any other off-loading measures, even though the facility residents who was dependent on tracheostomy/ventilator was at very high risk of developing pressure ulcers. The failure of not properly prevent, manage, and treat pressure injuries in accordance to the resident' plan of care, facility polices and professional standards of practice resulted in actual harm to Resident R1, R2, R3, R4, R6, R7, and R8, and placed the residents at the facility at high risk for harm and an Immediate Jeopardy situation. Immediate jeopardy was called on May 6, 2025 at 4:46 p.m. and the IJ Template was provided to the facility. 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. Pa Code 201.14 (a)Responsibility of Licensee Pa. Code 201.18 (a)Management