

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 06/09/2025
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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on review of clinical records and interview with staff, it was determined facility did not maintain medical records according to professional standards of practice for one of ten residents reviewed (Resident R3)</p> <p>Findings include:</p> <p>Review of facility policy charting and documentation, indicates that all services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record.</p> <p>Further review of policy indicates that documentation of procedures and treatments shall include care-specific details and may include: the name and title of the individual who provided care; how the resident tolerated treatment /procedure; whether the resident refused the procedure/treatment; notification of family, physician or other staff, if indicated and the signature and title of the individual documenting.</p> <p>Review of R3's clinical record on Monday, June 9, 2025, revealed a resident with medical history of anoxic brain injury (when brain doesn't receive enough oxygen), contracture of left hand, contracture of right hand, reduced mobility, muscle wasting and atrophy (partial or complete wasting away), tracheostomy status (surgical procedure where an opening is created in the neck to directly access the trachea for breathing), epilepsy (disorder in which nerve cell activity in the brain is disturbed, causing seizures), abnormal posture.</p> <p>Review of R3's care plan, initiated May 5th, 2025, revealed that she has activities of daily living self-care performance deficit related to disease process and requires two person assist for care for turning, transferring and repositioning.</p> <p>Further review of care plan revealed she is totally dependent on staff for personal hygiene and oral hygiene.</p> <p>Review of R3's physician orders revealed an order placed on May 5, 2025 for 2 person assist for care (turning, transferring and repositioning) every day and night shift for 2 person assist.</p> <p>Review of R3's electronic treatment administration record(e-TAR) revealed incomplete documentation for paired care for following dates: May 13, 2025 day shift, May 19, 2025 night shift, May 20, 2025 day shift, May 24, 2025 day shift, May 26, 2025 day shift.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Further review of physician orders revealed an order placed on April 5th, 2025 for bi-weekly bathing per patient preference every day shift every Wednesday, Saturday for bi-weekly skin evaluation Note - day shift must confirm bathing was completed before end of (nurse aide) shift at 3pm.</p> <p>Further review of e-TAR revealed incomplete bathing task for following dates: April 9th, 2025 day shift, April 16th, 2025 day shift.</p> <p>Findings confirmed with facility's administrator and assistant director of nursing.</p> <p>28 Pa Code 211.5(f)(ix) medical records</p> <p>28 Pa Code 211.12(d)(1) Nursing services</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and a review of facility policies and documentation, it was determined that the facility was not maintaining an effective pest control program.</p> <p>Findings include:</p> <p>A review of the undated facility Pest Control policy revealed that it states that the facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.</p> <p>A review of facility grievance report, dated April 17, 2025, revealed that a resident was sent back to the facility from an appointment at the hospital due to a bedbug being found on the resident causing his appointment to be cancelled. A review of pest control logs and reports from the pest control company revealed no further reports of follow up on this incident.</p> <p>A review of the pest control company's reports revealed that on May 28, 2025, the pest control company was called to the facility to for a bedbug found in room [ROOM NUMBER] which was checked by the pest control technician. The nurse had stored the bedbug in a specimen cup which was confirmed by the pest control technician in the report.</p> <p>An interview on June 9, 2025, at 1:30 p.m., with the Administrator, confirmed that the facility had a report from a hospital that a bedbug was found on a resident at an appointment in April of 2025 with no further reports of follow up on this incident, and had found a live bedbug in a resident room at the facility at the end of May. The administrator further stated that he had not reported this in the event reporting system.</p> <p>28 Pa. Code: 207.2(a) Administrator's responsibility</p> <p>28 Pa. Code: 201.18(b)(1)(3) Management</p>		