

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  12/12/2025
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.			
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F 0552  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments.  A review of the clinical record for Resident CL1 indicated an admission date of April 18, 2025, with diagnoses including respiratory failure with hypoxia, chronic obstructive pulmonary disease, tracheostomy, and dependence on renal dialysis. Review of Resident CL1's Minimum Data Set (MDS a periodic assessment of care needs), dated August 25, 2025, revealed a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. The clinical record also indicated that Resident CL1 had a Power of Attorney (POA) document on file, signed on February 17, 2025, granting the POA authority to make financial and insurance decisions on behalf of the resident. Continue review of the resident's clinical record revealed that the facility had Resident CL1 sign the insurance change form on September 29, 2025, instead of obtaining the signature or approval of the designated POA. On October 16, 2025, at 9:41 a.m., an interview was conducted with the Business Office Manager, who confirmed that the insurance change was signed by Resident CL1 and not by the POA. Although the POA documentation was present in the clinical record, the facility failed to involve the POA in the treatment decision related to the insurance change. On October 16, 2025, at 1:37 p.m. an interview with the Administrator and Assistant Director of Nursing confirmed that facility failed to have the Resident's CL1 representative in the decision related to an insurance change. 28 Pa. Code 201.14(a) Responsibility of licensee.		

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on interviews with residents and staff and review of clinical records, it was determined the facility failed to provide residents who is unable to carry out activities of daily living receives the necessary services to maintain personal hygiene related to incontinence care for four of 14 resident records reviewed (Resident R12, R17, R18, and R19). Findings include: Review of Resident R12's clinical records revealed an admission date of March 6, 2025, with the diagnoses of nontraumatic intracranial hemorrhage (bleeding), dysphagia (unable to swallow) following unspecified cerebrovascular disease, tracheostomy status, acute and chronic respiratory failure, hypertension, and gastrostomy. Review of Resident R12's annual MDS (minimum data set-an assessment of resident care needs) dated August 24, 2025. assessed the resident ' s cognition as severely impaired and completely dependent on staff for all activities of daily needs. During observation of Resident R12 receiving care by Nurses Aides (NA) Employee E9 and E10 on November 4, 2025, at 10:30 a. m. NAs stated Resident R12 was checked every two for incontinence, then it was documented it the resident was incontinent and what type of care was provided. Review of Resident R12 Bowel and Bladder Diary initiated on August 21, 2024, instructed the NA to document the resident ' s incontinence status Upon rising, after meals, at bedtime and as needed, every day, every shift: day, night, evening, nights 10-6. Review of the documentation revealed on October 16, 2025, at 2208 (10:08 p.m.) was the last time Resident R12 was documented receiving incontinence care, and not until, approximately 24 hours later, on October 17, 2025, at 2228, (10:29 p.m.) the resident was found and documented wet with bowel movement. On November 6, 2025, at 11:00 a.m. during an interview with three residents (Resident R17, R18, R19), alert and oriented, dependent on staff for incontinence care revealed complaints/concerns related to untimely incontinence care. Resident R18 stated, This past weekend, I had to lay in a saturated brief until morning. It happens often. Resident R17 stated, Call bell response is horrible. 7-3 and 3-11 will walk right by and pretend they don ' t know you need them. 11-7 they are not even in sight. When they do come, they have an attitude. Resident R19 stated, I had a yeast infection from not being changed properly. Resident R17 and Resident R19 both stated they and their daughters have complained multiple times to the facility. They both agreed that the facility says they will, Look into it ' , do something, ' Talk to the staff ' , but nothing changes. 28 Pa. Code 211.12(c)(d)(3)(5) Nursing services</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>Based on observation, interviews with staff, review of clinical records revealed the facility failed to ensure a resident at risk for pressure ulcers received care, consistent with professional standards of practice, to prevent pressure ulcers for one of 14 resident records reviewed (Resident R12). Findings include: Review of Resident R12's clinical records revealed an admission date of March 6, 2025, with the diagnoses of nontraumatic intracranial hemorrhage (bleeding), dysphagia (unable to follow) following unspecified cerebrovascular disease, tracheostomy status, acute and chronic respiratory failure, hypertension (high blood pressure), and gastrostomy. Physician orders dated September 12, 2025, instructed to don Prevalon boots (offloads pressure to reduce skin injuries) in bed/chair every day and night shift. Review of Resident R12's nursing notes dated October 29, 2025, stated the resident was found with an open area noted to right posterior lower leg above the ankle. The wound was documented measurements were, length 5.0, Width 2.5, and roughly 0.5 in Depth. Observation of Resident on November 3, 2025, and November 4, 2025, at 9:00 a. m. revealed that there were no Prevalon boots worn by the resident. November 4, 2025, at 10:30 a.m. during an interview with nurses ' aides (NA) Employee E9 and E10, the resident continued to be observed without Prevalon boots. NAs Employee E9 and E10 stated that a blister formed on the resident ' s leg and it popped. The aides stated the resident likes to cross his legs. Due to the boots not being used the resident was able to cross his legs which the area the two legs met was in the same area where the wound was found. The Director of Nursing was made aware of the above findings on November 4, 2025 at 11:00 a.m.28 Pa. Code 211.12 (d)(5) Nursing Services.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>Based on observation, interviews with staff and review of resident clinical records, it was determined that the facility failed to ensure a resident with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion related to splinting for one of 14 resident records reviewed (Resident R12). Findings include: Review of Resident R12's clinical records revealed an admission date of March 6, 2025, with the diagnoses of nontraumatic intracranial hemorrhage (bleeding), and tracheostomy status. Review of Resident R12's physician orders dated August 22, 2025, instructed to place a clean rolled gauze in right hand for passive stretch and in the left hand a carrot orthosis up to six hours on for contracture management. Review of Resident R12's care plan revealed that a care plan was developed on October 30, 2023 for a resting hand splints to be worn during daytime for 6-8 hours. Observation of Resident R12 on November 4, 2025, at 10:30 a.m., with nurses' aide (NA) Employee E9 and E10, revealed there was no rolled gauze in place on the resident's right hand. Interview with NA, Employee E9 at the time of the observation revealed that the gauze was for wound care and the wound care nurse would place the gauze in the residents hand. Interview conducted with the Director of Rehabilitation on November 6, 2025, at 10:00 a. m. revealed that the gauze that was to be placed on the resident's right hand was used for contractures not for wound care. 28 Pa. Code 211.12 (d)(5)(5) Nursing Services.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of clinical records, observations, and staff interviews, it was determined that the facility failed to ensure safety interventions for falls were in place for two of four residents reviewed for falls (Resident R11, R20). Findings include: Clinical record review revealed Resident R11 was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease (condition that prevents airflow to the lungs, causing breathing problems), hemiplegia and hemiparesis (affects movement/sensation on one side of body), and cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it). Review of Resident R11 's care plan, revised September 19, 2025, revealed the resident is at moderate risk for falls related to confusion, deconditioning, and unaware of safety needs. The resident substantiated a fall that occurred on September 02, 2025 when resident slid out of wheelchair and another fall from bed on September 16, 2025. Further review of Resident R11 's care plan for falls revealed fall mats were to be applied to bilateral sides of the bed. Observation on November 03, 2025 at 10:12 a.m. revealed Resident R11 lying in bed and did not have bilateral floor mats on the floor next to the bed. Follow-up observation on November 03, 2025 at 1:10 p.m. revealed Resident R11 lying in bed and did not have bilateral floor mats on the floor next to the bed. Interview on November 03, 2025, at 1:22 p.m., with Employee E7, Nurse Aide, confirmed Resident R11 did not have bilateral floor mats on the floor while in bed. Review of clinical record revealed Resident R20 was admitted to the facility on [DATE], with a diagnose of amyotrophic lateral sclerosis (also known as [NAME] 's Disease, a neurodegenerative disease affecting nerve cells in the brain and spinal cord, which leads to loss of muscle control) and myasthenia gravis (chronic autoimmune disorder leading to muscle weakness and fatigue). Review of Resident R20 's care plan, initiated May 17, 2025, revealed Resident R20 was at risk for falls and interventions included bilateral fall mats to be in place. Observation on November 05, 2025 at 11:30 AM revealed Resident R20 had one fall mat on the right side of the bed in place. Interview with Employee E8, Licensed Practical Nurse, confirmed Resident R20 only had the right-side fall mat in place. 28 Pa. Code 211.12 (d)(5) Nursing Services.</p>

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of clinical records, facility policy, and staff interview, it was determined that the facility failed to provide culturally competent, trauma care in accordance with professional standards of practice, accounting for the resident's past experiences and preferences in order to eliminate and/or mitigate triggers that may cause re-traumatization of the resident for one of two residents sampled for post-traumatic stress disorder(PTSD). (Resident R7).Findings include:A review of the clinical record revealed that Resident R7 was admitted to the facility on [DATE] with diagnoses to include traumatic subarachnoid hemorrhage (a collection of blood that accumulates between the inner layer of the skull), traumatic brain injury (occurs when external force causes damage to the brain), and post-traumatic stress disorder (PTSD) (a mental health condition that develops after experiencing or witnessing a traumatic event, such as a natural disaster, war, violent crime, or personal loss).Resident R7's care plan, initiated July 08, 2025, revealed no care plan was developed for history of traumatic events. Further review of the care plan did not address possible triggers that may cause re-traumatization.Interview with the Director of Nursing, Employee E2, on November 06, 2025 at 11:30 a.m., confirmed Resident R7 ' s care plan was developed for the resident ' s diagnosis of PTSD and possible triggers that may cause re-traumatization. 28 Pa. Code 211.12(c)(d)(3)(5) Nursing services</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> A review of the facility policy titled, Isolation-Initiating Transmission-Based Precautions undated, revealed Transmission-Based Precautions will be initiated when there is reason to believe that a resident has communicable infection disease. Transmissions-Base Precautions may include Contact Precautions, Droplet Precaution, or Airborne precautions:A review of Resident R2's clinical record revealed that the resident was admitted to the facility on [DATE], with a physician's order on the same date for tracheostomy and hemodialysis. The clinical record also included special instructions for enhanced barrier precautions due to open insertion sites related to these treatments.On October 16, 2025, at 9:19 a.m., a tour with the Assistant Director of Nursing and Infection Preventionist, Employee E2, revealed that the facility provides bedside hemodialysis to residents. All such residents have special instructions to follow transmission-based precautions, and all staff entering their rooms must wear personal protective equipment (PPE), including a gown, gloves, and mask, when providing care or treatment. It was further observed that four hand sanitizing dispensers near rooms 738, 735, 733, and 731 were empty. In addition, the public restroom on the east side of the nursing unit lacked soap and paper towels.On October 16, 2025, at 9:21 a.m., dialysis patient care technician Employee E3 was observed providing bedside dialysis treatment to Resident R2 without wearing appropriate personal protective equipment (PPE). This was confirmed by the Assistant Director of Nursing, Employee E2.On October 16, 2025, at 10:37 a.m. dialysis patient care technician Employee E3 was interviewed and confirmed that it was my mistake for not wearing the PPE.A review of Resident R3's clinical record revealed that the resident was admitted to the facility on [DATE], with a physician's order on the same date for a feeding tube and an indwelling urinary foley catheter. Continued review of Resident R3's clinical record included special instructions for enhanced barrier precautions.On October 16, 2025, at 9:27 a.m., observations were conducted with the Assistant Director of Nursing, Employee E2, who confirmed that licensed nurse Employee E4 was providing care to Resident R3 without wearing appropriate personal protective equipment (PPE).28 Pa. Code 211.10 (d) Resident care policies.28 Pa. Code 211.12 (d)(5) Nursing services.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interviews with residents and staff, and review of facility documentation, it was determined that the facility failed to ensure that call bells were functioning properly for 6 of 6 resident rooms. (Rooms-717 (A and B), 723, 720-(A and B), 728-B and 733-B) Findings include: Review of Facility 's policy for Call Bells revealed (within Item 3 of Guidelines) that For any defective call lights, inform maintenance. Residents may be offered with a tap bell to use if and when applicable. Observations on November 5, 2025, at 11:30 AM and November 7, 2025, at 11:35 AM of call light of Residents ' call bell in room [ROOM NUMBER]-A and B, revealed that at both times call bell box had been pulled out of the wall and was therefore rendered defective/ineffective. Further observation revealed that the call bell did not illuminate outside room when the resident pushed call bell button, Resident R20 had not been provided with an alternative of a tap bell as per facility Call Bells Policy. Observation and interview with Resident R21 on November 4, 2025, at 12:00 p.m. stated the resident ' s call bell in room [ROOM NUMBER]-B has not worked in months. Observed was a small silver manual bell that the resident was told to use if staff attention was needed. Review of a grievance, dated October 17, 2025 family reported Resident R22 ' s call bell in room [ROOM NUMBER] has not worked in approximately two weeks since the resident ' s admission, instead was giving a manual bell. On November 6, 2025, at 11:00 a.m. during an interview with four residents (Resident R17, R18, R19 and R23), in rooms 720-A and B, 728-B and 733-B stated their call bells have not worked for weeks. They are given a small manual bell that the staff do not respond. On November 4, 2025, at 1:00 p.m. during an interview with the Nursing [NAME] Administrator, stated the facility does not have an effective process for informing maintenance when something needs repair. Maintenance is told verbally and that recently the staff was trained on how to use the computerized TELS system that goes directly to maintenance. 28 Pa Code 201.18(b)(3) Management</p>		