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	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at East Falls	3300 Henry Avenue, 7th Floor Philadelphia, PA 19129

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on the review of facility documentations, interview with resident group, and staff interviews, it was determined that the facility failed to post most recent survey results which include any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility readily accessible to residents, and family members and legal representatives of residents.Findings include:Interview with residents during resident council meeting held with the surveyor on July 29, 2025, at 11:00 a.m., (Resident R14, R18 and R21 participated in the meeting) stated they were not aware of the availability of the survey results.Observation of the facility reception area on July 29, 2025, at 12:19 p.m. revealed that there was state survey inspection results available in a binder at the reception area.Review of the binder revealed that the most recent recertification results were not available in the binder.Complaint survey results of the survey of June 9, 2025, were not available.Complaint survey results of the survey of February 20, 2025, were not available.Complaint survey results of the survey of January 28, 2025, were not available.Complaint survey results of the survey of November 21, 2025, were not available.Interview with Regional facility staff on July 29, 2025, at 12:19 p.m. confirmed the above finding. 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, clinical record reviews, facility documentation and interviews with staff, it was determined that the facility failed to ensure that a physical restraint was used according to the professional standards of practice for one of two residents reviewed. (Resident R23).Findings include: Review of an undated facility policy Use of Restraints, revealed that Physical Restraints are defined as by the Centers for Medicare and Medicaid_ Services (CMS) as any, manual method or physical or mechanical device, material or equipment attached or adjacent to the residents body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. The definition of a restraint is based on the functional status of the resident and not the device. If the restraint cannot remove a device in the same manner in which the staff applied it given that residents physical condition i.e., side rails are put back down, rather than climbed over), and this restricts his/ her typical ability to change position or place, that device is considered a restraint. Restraint Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and or representative. The order shall include the followinga. the specific reason for the restraint as it relates to the residence medical symptomb. how the restrain will be used to benefit the resident's medical symptomc. the type of the restraint and the period of time for the use of restraint. The following safety guidelines shall be implemented and documented while resident is restraints:a. Restraint shall be used in such a way as not to cause physical injury to the resident and to ensure the least possible discomfort to the residentb. Physical restraints shall be applied in such a manner that they can be speedily removed in case of fire or other emergency.c. The opportunity for motion and exercise is provided for a period of not less than 10 minutes during each two hours in which restraints are employedd. Restrained residents shall be repositioned at least every two hours on all shifts.Review of manufacture recommendation for Posey Bed revealed that The Posey Bed 8070/8075 is a hospital bed, canopy and mattress system designed to help provide a safe, controlled environment for patients at extreme risk of injury from a fall or unassisted bed exit. The Posey Enclosure Bed is intended to provide a safe, controlled environment for patients at risk of injury from unassisted bed exit or at risk of injury to self or others. The Posey Bed is a restraint, and must be prescribed by a licensed physician, for use only in healthcare facilities. Improper use of the Posey Bed 8070/8075 may lead to serious injury or death. Patient monitoring should be determined by hospital protocol, a doctor, and the patient care plan. As with any less restrictive restraint system, it is important to understand when the Posey Bed 8070/8075 is needed, when it should not be used, and the dangers related to entrapment, suffocation, choking, and falls.A soft side rail is located on each side of the bed. The perimeter guards should be zipped into the up position and secured with the quick-release buckles when the U-shaped side panel is open for patient care.Canopy gaps present an entrapment risk for certain at-risk patients. Raising the head of the Posey Bed creates gaps or pockets between the head of the bed and the canopy. These areas pose an extreme risk of serious injury or death from entrapment for certain at-risk patients. Keep the mattress flat with the head of the bed down when an at-risk patient is alone. Use Posey Filler Cushions (Cat. 8021) if an at-risk patient's head or torso must be elevated (for example, while watching TV, or if called for by the doctor's order or the patient's care plan). Monitor patient to make sure that the Posey Filler Cushions cannot be removed by an at-risk patient and that an at-risk patient cannot crawl under or around the Posey Filler Cushions. (Adhere to the facility's restraint protocol, if applicable.) The canopy may stretch over time during normal use or by patients who engage in escape behaviors. This could result in pocket areas on the inside of the canopy.Review of MDS (Minimum Data Set-Assessment of Resident Care Needs) for Resident R23 dated July 3, 2025, revealed that resident had severely impaired cognitive decision making skills.Observation of Resident R23's room on July 28, 2025, at 11:28 a.m. revealed that the resident was using a fully enclosed net bed. Resident was observed moving in the bed from side to side There was a gap in between the net and the mattress. There was no filler cushion available. Further observation revealed that the resident was receiving oxygen via oxygen cannula.Interview with the Nursing Assistant, Employee E12 on July 28, 2025, at 11:40 a.m. stated she was not aware of the specifics of the bed. Employee stated she was also not aware safety inspections of bed or what to check when the resident was in bed. Employee also stated she did not receive any training about the bed. Interview with Licensed Practical Nurse, Employee E13 who was assigned to the resident stated the resident move a lot in the bed and she was worried about resident suffocating with pillows in the bed and the oxygen cannula. Employee stated the resident was thin and that increased the chance for her to get entrapped in the bed

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of facility documentation, review of clinical records, and interviews with staff, it was determined that the facility failed to notify the Office of the State Long-Term Care Ombudsman of facility-initiated transfers to the hospital in writing, for one of three clinical records reviewed. (Resident R56)Findings include:Review of Resident R56's clinical record revealed that Resident R56 was discharged on May 8, 2025.Upon request, the facility was not able to produce proof that the facility sent a copy of the discharge notice to a representative of the Office of the State Long-Term Care Ombudsman.Interview with Employee E1, Administrator, conducted on July 31, 2025, at 3:00 p.m. revealed the facility did not have proof that the facility sent a copy of the discharge notice to a representative of the Office of the State Long-Term Care Ombudsman. Administrator stated facility could not locate any discharge notification for the month of May 2025.28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(2) Management

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and review of clinical records and facility policies it was determined that the facility failed to develop and implement a comprehensive person-centered care plan for one resident related to restorative therapy and range of motion for two of 22 resident records reviewed (Resident R6 and Resident R11). Findings include:Review of the facility Care Plan policy indicated an individualized care plan includes measurable objectives and timetables to meet the Resident's medical, nursing, mental, and psychological needs is developed for each resident. Review of the facility policy on Care Plans section Policy revealed that an individualized care plan that include measurable objective and timetable to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Under section Policy Interpretation and Implementation. #1. AristaCare at East Falls Planning/Interdisciplinary Team, in coordination with the resident, his/her family, or representative develops and maintains a care plan for each resident that identifies the highest level of functioning the resident may be expected to maintain.Review of the facility policy titled Rehabilitative Nursing Care, undated, states that rehabilitative nursing care is provided for each resident admitted , nursing personnel are trained in rehabilitative nursing care to assist each resident to achieve and maintain an optimal level of self-care and independence and is performed daily who require such service. Furthermore, the same policy states the residents' care plan, the goals of rehabilitative nursing care are reinforced. Review of Resident R6's clinical records revealed the resident was admitted to the facility on [DATE]. 2024 and was diagnosed with hemiplegia and hemiparesis (paralysis of one side of the body) following unspecified cerebrovascular disease affecting the right dominant side.Review of Resident R6' physician orders revealed restorative nursing therapy (RNP) for range of motion exercises to the upper extremities.Further review of Resident R6's clinical record revealed no care plan was developed for the resident's RNP therapy. Observation conducted on July 29, 2025, at 12:32 PM revealed that Resident's R11 upper extremity was flexed.Review of Resident R11's physician' order dated July 24, 2025, revealed an order for: RNP (Restorative Nursing Program): BLE (both lower extremity) AROM (assistive range of motion) exercises through all available planes of motion and direction.Review of physician's order dated July 16, 2025, revealed an order for: RNP: RIGHT UE (upper extremity)- Right T-Bar orthosis/splint up to 6 hours on, skin checks pre/post application, for contracture management.Review of physician's order dated July 16, 2025, reveled an order for: RNP: BUE (both upper extremity) AAROM (active assistive range of motion), 3 sets/10 reps all joints/planes as tolerated.Review of MDS (minimum data set- a federally required resident assessment completed at a specific interval) dated July 3, 2025, section GG0115. Functional Limitation in Range of Motion, A. Upper extremity (shoulder, elbow, wrist, hand) was coded as limitation on one side. Review of Resident R11's care plan list revealed that there was no person-centered care plan related to limitation in range of motion was developed.28 Pa Code 211.10(c) Resident care policies28 Pa Code 211. 12(d)(1) Nursing services

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interview with resident's representative, staff interview and review of clinical records, it was determined that the facility failed to provide showers for one of five residents reviewed dependent on staff for activities of daily living. (Resident R49)Findings include:Clinical record review for Resident R49 revealed that his admission diagnoses included dependence on respirator and functional quadriplegia.Review of Resident R49's quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated July 3, 2025, revealed that Resident R49 was totally dependent on staff for activities of daily living to include bed mobility, transfers, toilet use and showers. Continued review of the MDS revealed that the resident's cognition was severely impaired with a BIMS score of 99 (Brief Interview for Mental Status - a tool to assess cognitive function; a score of 99 which indicates the resident was unable to complete interview). The MDS indicated that Resident R1 was rarely/never understood by others when the resident attempted to speak and rarely/never understood when others spoke to the resident.Review of Resident R49's care plan dated December 6, 2025, revealed that the resident would like her hair washed during showers at least once a week and staff would wash resident's hair.Review of Resident R49's task record revealed that the resident was scheduled for showers twice a week on Wednesday and Saturday on 3pm-11pm shift.Review of facility investigation dated July 22, 2025, revealed that the resident was noted with an open area on back of head and the family felt it was a result of neglect of care. Further review of the investigation revealed that the open area most likely caused by tightly braided hair.Interview with Resident R49's representative on July 31, 2025, at 3:08 p.m. stated resident was not getting her hair done at all and staff would not wash her hair as requested. Resident representative stated that staff need to scrub and reach her scalp which they did not do often. He stated resident's hair became filthy. He stated back in December of 2024 he asked them to wash the resident's hair at least once with shower, because it was difficult to clean the scalp in bed, but the resident did not even get showers at least monthly.Review of task documentation for Resident 49 revealed that from July 1 to July 30, 2025, the resident only received one shower. Resident did not receive bathing or shower on July 12, 2025.Interview with the Director of Nursing on July 31, 2025, at 2:00 p.m. confirmed that there was no documented evidence that the resident received hair shower with washing of hair according to the care plan. 28 Pa. Code 211.12 (d)(1) Nursing Services28 Pa. Code 211.12 (d)(5) Nursing Services

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on observations, review of facility documentation, staff and resident interviews, it was determined that the facility failed to provide an ongoing program of activities to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities for three of three residents reviewed. (Residents R14, R18 and R21).Findings include:Interview with residents during resident council meeting held on July 29, 2025, at 11:00 a.m. with Resident R14, R18 and R21 stated they do not have any activity program in the facility.Resident R21 stated the facility were supposed to provide his favorite group program like Bingo but the facility did not provide any group activities lately.Resident R18 stated the last activity program she attended was on July 4, 2025 and no other activity program since then.Resident R14 stated she did not attend any activity program.Review of July 2025 activity program revealed that there were no group activities on weekends, the only activity program listed on weekend was Independent Leisure. Observation of the facility on July 28, 2025, revealed there was no activity program and no activity staff available at the facility.Interview with the administrator on July 29, 2025, at 2:00 p.m. stated facility did not have any activity staff. Administrator confirmed that there was no activity program provided according to the activity calendar in July 2025.28 Pa. Code 201.18(e)(6) Management

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on a review of clinical records and facility policies, observations and staff interviews, it was determined that the facility failed to timely and consistently provide recommended and/or prescribed treatment and services, consistent with professional standards of practice, to prevent new pressure sore development, promote healing and prevent worsening of existing pressure sores related to turning and repositioning for three of seven residents reviewed. (Resident R52, R47 and R5)Findings include:Review of care plan for Resident R52 dated July 25, 2023, revealed that resident was totally dependent on staff to turn and reposition in bed every 2 hours.Review of physician order for resident R52 dated May 3, 2025, revealed an order to turn and reposition every 2 hours. Observation of Resident R52 on July 29, 2025, at 10:20 a.m. revealed that the resident was lying in bed on her back with one pillow on the left side and one pillow under the right hand. There was a wedge cushion on the floor to the left side of the bed. Further observation of Resident R52 on July 29, 2025, at 12:22 p.m. revealed that the resident was lying in bed on her back with one pillow on the left side and one pillow under the right hand, similar position as observed at 10:20 a.m. There was a wedge cushion still on the floor to the left side of the bed. Continued observation of Resident R52 on July 29, 2025, at 2:20 p.m. revealed that the resident was lying in bed on her back with one pillow on the left side and one pillow under the right hand, similar position as observed at 10:20 a.m. There was a wedge cushion still on the floor to the left side of the bed. Observation of Resident R52 on July 30, 2025, at 10:03 a.m. revealed that the resident was lying on her back with wedge on left side and under the thigh and pillow on both sides. There was a wedge cushion on the floor to the left side of the bed. Observation of Resident R52 on July 30, 2025, at 12:00 p.m. revealed that the resident was lying on her back with wedge on left side and under the thigh and pillow on both sides. There was a wedge cushion on the floor to the left side of the bed. Continued observation of Resident R52 on July 30, 2025, at 1:01 p.m. revealed that the resident was at the same position from 12:00 p.m.Review of Nurse Aide documentation of Resident R52 for turn and reposition revealed that there was no documented evidence for the completion of the task as ordered for July 29, 2025 7am to 3pm shift and only one shift documentation available for July 30, 2025.Review of care plan for Resident R47 dated September 6, 2024, revealed that resident was at risk for impaired skin and staff to turn and reposition in bed every 2 hours.Review of physician order for resident R47 dated May 3, 2025, revealed an order to turn and reposition every 2 hours. Observation of Resident R47 on July 29, 2025, at 10:21 a.m. the resident was lying in bed on her back with no pillows or wedge cushion. There was wedge cushion and splints on the floor. Observation of Resident R47 on July 29, 2025, at 12:21 p.m. the resident was lying in bed on her back with no pillows or wedge cushion, similar position from 10:21 a.m. There was wedge cushion and splints on the floor. Continued observation of Resident R47 on July 29, 2025, at 2:20 p. m. revealed that the resident was at a similar position. Review of Nurse Aide documentation of Resident R47 for turn and reposition revealed that there was no documented evidence for the completion of the task as ordered for July 29, 2025, 7am to 3pm shift and only one shift documentation available for July 30, 2025. Review of care plan for Resident R5 dated February 24, 2024, revealed that resident actual skin impairment. There was no care plan intervention for turning and repositioning or heel offloading. Review of physician order for resident R5 dated May 3, 2025, revealed an order to turn and reposition every 2 hoursObservation of Resident R5 on July 29, 2025, at 10:22 a.m. revealed that the resident was lying in bed on her back. Resident did not have any heel offloading measures in place. Observation of Resident R5 on July 29, 2025, at 12:24 p.m. revealed that the resident was lying in bed on her back, similar position as observed at 10:22 a. m. Resident did not have any heel offloading measures in place. Continued observation of Resident R5 on July 29, 2025, at 2:21 p.m. revealed that the resident was lying in bed on her back, similar position as observed at 10:22 a.m. and at 12:24 p.m Resident did not have any heel offloading measures in place. Observation of Resident R5 on July 30, 2025, at 10:01 a.m. revealed that the resident was lying in bed on her back.Observation of Resident R5 on July 30, 2025, at 12:01 p.m. revealed that the resident was lying in bed on her back.Continued observation of Resident R5 on July 30, 2025, at 1:01 p.m. revealed that the resident was at the same position in bed as observed at 10:01 a.m. and at 12:01 p.m.Review of Nurse Aide documentation of Resident R5 for turn and reposition revealed that there was no documented evidence for the completion of the task as ordered for July 29, 2025, 7am to 3pm shift and only one shift documentation available for July 30, 2025.Interview with Nurse Aide, Employee E15 on July 29, 2025, at 2:20 p.m. she did not turn and reposition Resident R52, R47 and R5 because the resident had tube feeding and contractures

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, interviews with resident and staff, and review of clinical records and facility policy it was determined the facility failed to ensure rehabilitative nursing care was provided to one of 14 resident records reviewed (Resident R6)Findings include:Review of the facility policy titled Rehabilitative Nursing Care, undated, states that rehabilitative nursing care is provided for each resident admitted , nursing personnel are trained in rehabilitative nursing care to assist each resident to achieve and maintain an optimal level of self-care and independence and is performed daily who require such service. Furthermore, the same policy states the residents' care plan, the goals of rehabilitative nursing care are reinforced. Review of Resident R6's clinical records revealed the resident was admitted to the facility on [DATE]. 2024 and was diagnosed with hemiplegia and hemiparesis (paralysis of one side of the body) following unspecified cerebrovascular disease affecting the right dominant side.Review of Resident R6's physician orders revealed the resident was ordered restorative nursing therapy (RNP) for the resident's upper extremities. The same order instructed to apply a right upper extremity splint, up to 6 hours, as tolerated, with skin checks pre/post application, dated May 6, 2025. Review of the restorative aide documentation revealed therapy was only conducted 7 out of the last 30 days in July 2025. Observation of Resident R6 on July 30, 2025, at 1:00 p.m. was observed lying in bed without the splint in use on the right arm. The resident who was nonverbal motioned she does not like the splint and does not like to use it. The resident also motioned that the resident receives therapy but not all of the time.Interview with the restorative aide Employee E11 on July 30, 2025, at 1:05 p.m. explained the RNP is not being done daily/consistently as ordered due to insufficient staffing. When there are not enough nursing assistants (NA) for resident care the RNP aide is taken off the RNP schedule and replaced as a NA. 28 Pa Code 211.12(d)(1)(3) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon interviews, review of clinical records and facility documentation and policy it was determined the facility failed to adequately supervise a resident who left the facility without notice for one of 14 resident records reviewed (Resident R8).Finding include: Review of facility policy titled Elopement undated states, Staff shall investigate and report all cases of missing residents. 1. Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the charge nurse, DON, or Administrator. 2. If an employee observes a resident leaving the premises he/she should: Attempt to prevent the departure in a courteous manner. Get help from other staff members in the immediate vicinity, if necessary. Instruct another staff member to inform the charge nurse, DON, or Administrator that a resident has left the premises. Employee should go with the resident and stay with them when applicable or needed, call 911 for assist 3. When a departing individual returns to the facility, the DON or Charge Nurse shall: Examine the resident for injuries. Notify the attending physician. Notify the resident's legal representative (sponsor) of the incident. Complete and file Report of Incident/Accident; and 4. If an employee discovers the resident is missing from the facility, he/she shall: Determine if the resident is out on an authorized leave or pass. If the resident was not authorized to leave, initiate search of the building(s) and premises. If the resident is not located, notify the administrator and the Director of Nursing Services, the resident's legal representative (sponsor), the attending physician, law enforcement officials, and (as necessary) volunteer agencies (i.e., emergency management, rescue squads, etc.). Call 911 for assistance Provide search teams with resident identification information. Initiate an extensive search of the surrounding area. The administrator/designee will determine if it's a reportable occurrence.Resident R8 was admitted to the facility on [DATE], diagnosed with a thoracic spinal cord injury, and was paraplegic (inability to move the low part of the body). Review of Resident R8's admission MDS (Minimum Data Set- is an assessment of residents' needs) dated July 2, 2025, revealed the resident was alert and oriented, independent with all activities of daily living, bed mobility and transfers and used a wheelchair for ambulating. Review of Resident R8's nursing progress note on June 21, 2025 at 1:52 a.m. stated, Spoke w/ Administrator & DON (Director of Nursing) about when I went to speak w/ on call about his meds (medications) resident was not in room, After resident coming back into the building he stated I went out for air educated on policy about going outside smoking and signing out policy and AMA (against medical advice) policy.Review of facility documentation indicated on June 20, 2025, at approximately 11:30 p. m. Resident R8, Left the facility premises on his own unbeknown to facility staff. The report also indicated the resident was unaware of the facility policy related to leaving the facility.Surveyor interviewed Resident R8 on July 31, 2025, at 12:00 p.m. that stated, They (facility staff) didn't find me, I came back on my own. I went to a gas station 2 blocks over. I know this area; I use to live here.28 Pa. Code 211.10(d) Resident care policies28 PA. Code 211.12(c)(d)(1) Nursing services

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, review of clinical record, review of facility policy and competencies, revealed that the facility did not ensure that checks for proper placement of gastric tubes were conducted before medication administration via gastric tube for one of three residents observed. (Resident R59)Findings include:Review of facility competency on Medication administration-through a feeding tube #5. Checks tube for placement, and patency prior to administration of meds.Review of facility policy on Confirming Placement of Feeding Tube revealed that under section Purpose: The purpose of this procedure in to ensure proper placement of the feeding tube to prevent aspiration during feeding. Under section Steps in the Procedure: #4. Attach 50 to 60 cc syringe with 10 cc of air to the end of the tube. #5. If tube is clamped, unclamp, #6. Place stethoscope 2 to 3 inches below the xyphoid process. #7. Forcefully inject 10 cc of air into the tube while listening to the abdomen with stethoscope for a whooshing sound. #8. Verification of placement of tube is complete when whooshing sound is heard.Review of facility policy on Administering Medications section Policy statement revealed that Medications shall be administered in a safe and timely manner and as prescribe. Review of Resident R59's clinical record revealed that Resident R59 was admitted to the facility on [DATE]. Review of facility competency on Medication Administration-through a feeding tube #5. Checks tube for placement, and patency prior to administration of meds. 4 with diagnoses of but not limited to Acute and Chronic Respiratory Failure and Gastrostomy status.Review of physician's orders revealed an order for: NPO (nothing per mouth) status at all times dated June 25, 2025.Medication administration observation conducted with Licensed nurse, Employee E4 on July 30, 2025, at 8:57 AM revealed that during medication administration for Resident R59, Employee E4 proceeded to administer Resident R59's medication via gastrostomy tube using a large syringe via gravity without checking for placement of the gastrostomy tube (aspirate stomach content or inject air into the tube and listen for the whoosh sound). Further, Employee E4 did not have a stethoscope with her during medication administration.Interview with Licensed nurse, Employee E4 conducted at the time of the observation revealed she pushed air, but she did not use a stethoscope. Further, Employee E4 revealed that she can hear without the use of a stethoscope. Further interview with Licensed nurse, Employee E4 revealed that her stethoscope was in the medication cart. Inspection of the medication cart after medication administration revealed that there was no stethoscope in the med cart. Interview with Employee E4 confirmed that there was no stethoscope in the medication cart.28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of clinical record, staff interview and review of facility policy, it was determined that the facility did not ensure that residents receive oxygen according to physician's orders for one of two residents reviewed. (Resident R11)Findings include: Review of facility policy on Oxygen administration under section Purpose: The purpose f this procedure is to provide guidelines for oxygen administration. Under section Preparation: #1. Verify that there is a provided order for this procedure. Review the physician's order or facility protocol for oxygen administration. #2. If resident requests it due to shortness of breath etc., a provider will be notified. Review of Resident R11's clinical record revealed that Resident R11 was admitted to the facility on [DATE], with diagnoses of but not limited to Acute and Chronic Respiratory Failure with Hypoxia (low levels of oxygen).Further review of Resident R11's clinical record revealed that Resident R11 did not have a physician's order for oxygen.Observation conducted on July 29, 2025, at 12:42 PM revealed that Resident R11 was in bed awake with oxygen via nasal cannula at 3 liters/minute. Interview with Licensed nurse, Employee E5 confirmed that Resident R11 was on 3 liters of oxygen via nasal cannula. Interview with Respiratory therapist, Employee E6 conducted on July 29, 2025, at 1:13 PM confirmed that resident was placed on 3 liters of oxygen. Further Employee E6 also confirmed that there was no physician's order for oxygen for Resident R11. Employee E6 revealed that resident was decannulated on July 22, 2025, and desaturated thereafter and has been on oxygen since without any physician's orders.Follow-up interview with Respiratory therapist, Employee E6 conducted on July 29, 2025, at 1:40PM revealed that she asked the physician to write an order for oxygen and that the physician ordered only 2 liters/minute.Review of physician's order confirmed that an order was obtained for oxygen at 2 liters/minute on July 29,.2025 at 1:35PM.28 Pa. Code 211.12 (d)(1)(5) Nursing services

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on the review of facility staffing schedule, clinical records, and interviews with staff, residents and resident representative, it was determined that the facility failed to ensure sufficient nursing staff to provide nursing related to interventions to prevent pressure ulcer and restorative nursing services for four of seven residents reviewed. (Residents R52, R47, R5, and R6)Review of an undated facility policy Prevention of Pressure Ulcers, revealed that Identify risk factors for pressure ulcer development 2. For a person in bed. a. Change position at least every two hours or more frequently if needed.Interview with Resident R14, R18 and R21 during resident council meeting held on July 29, 2025, at 11:00 a.m., stated the facility did not have sufficient staffing. Residents stated call bells often take longer to answer and sometimes it could even take one or two hours. Residents also stated activities of daily living (hygiene, mobility, dining-eating, communication) take longer due to low staffing.Interview with Resident R49's representative on July 31, 2025, at 3:08 p.m. stated resident was not getting her hair done at all and staff would not wash her hair as requested stated facility had severe staffing shortages. Review of care plan for Resident R52 dated July 25, 2023, revealed that resident was totally dependent on staff to turn and reposition in bed every 2 hours. Review of physician order for resident R52 dated May 3, 2025, revealed an order to turn and reposition every 2 hours. Observation of Resident R52 on July 29, 2025, at 10:20 a.m. revealed that the resident was lying in bed on her back with one pillow on the left side and one pillow under the right hand. There was a wedge cushion on the floor to the left side of the bed. Further observation of Resident R52 on July 29, 2025, at 12:22 p.m. revealed that the resident was lying in bed on her back with one pillow on the left side and one pillow under the right hand, similar position as observed at 10:20 a.m. There was a wedge cushion still on the floor to the left side of the bed. Continued observation of Resident R52 on July 29, 2025, at 2:20 p.m. revealed that the resident was lying in bed on her back with one pillow on the left side and one pillow under the right hand, similar position as observed at 10:20 a.m. There was a wedge cushion still on the floor to the left side of the bed. Observation of Resident R52 on July 30, 2025, at 10:03 a.m. revealed that the resident was lying on her back with wedge on left side and under the thigh and pillow on both sides. There was a wedge cushion on the floor to the left side of the bed. Observation of Resident R52 on July 30, 2025, at 12:00 p.m. revealed that the resident was lying on her back with wedge on left side and under the thigh and pillow on both sides. There was a wedge cushion on the floor to the left side of the bed. Continued observation of Resident R52 on July 30, 2025, at 1:01 p.m. revealed that the resident was at the same position from 12:00 p.m.Review of Nurse Aide documentation of Resident R52 for turn and reposition revealed that there was no documented evidence for the completion of the task as ordered for July 29, 2025 7am to 3pm shift and only one shift documentation available for July 30, 2025.Review of care plan for Resident R47 dated September 6, 2024, revealed that resident was at risk for impaired skin and staff to turn and reposition in bed every 2 hours.Review of physician order for resident R47 dated May 3, 2025, revealed an order to turn and reposition every 2 hours. Observation of Resident R47 on July 29, 2025, at 10:21 a.m. the resident was lying in bed on her back with no pillows or wedge cushion. There was wedge cushion and splints on the floor. Observation of Resident R47 on July 29, 2025, at 12:21 p.m. the resident was lying in bed on her back with no pillows or wedge cushion, similar position from 10:21 a.m. There was wedge cushion and splints on the floor. Continued observation of Resident R47 on July 29, 2025, at 2:20 p.m. revealed that the resident was at a similar position. Review of Nurse Aide documentation of Resident R47 for turn and reposition revealed that there was no documented evidence for the completion of the task as ordered for July 29, 2025, 7am to 3pm shift and only one shift documentation available for July 30, 2025. Review of care plan for Resident R5 dated February 24, 2024, revealed that resident actual skin impairment. Review of physician order for Resident R5 dated May 3, 2025, revealed an order to turn and reposition every 2 hoursObservation of Resident R5 on July 29, 2025, at 10:22 a.m. revealed that the resident was lying in bed on her back. Resident did not have any heel offloading measures in place. Observation of Resident R5 on July 29, 2025, at 12:24 p.m. revealed that the resident was lying in bed on her back, similar position as observed at 10:22 a.m. Resident did not have any heel offloading measures in place. Continued observation of Resident R5 on July 29, 2025, at 2:21 p.m. revealed that the resident was lying in bed on her back, similar position as observed at 10:22 a.m. and at 12:24 p.m Resident did not have any heel offloading measures in place. Observation of Resident R5 on July 30, 2025, at 10:01 a.m. revealed that the resident was lying in bed on her back.Observation of Resident R5 on July 30, 2025, at 12:01 p.m. revealed that the resident was lying

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of personnel files and staff interviews, it was determined that the facility failed to ensure that staff demonstrated competency in skills and techniques necessary to care for residents with a restraint in bed and during medication administration via gastrointestinal tube for four of four nursing staff reviewed. (Employees E4, E14, E17 and E18)Findings include:Observation of Resident R23's room on July 28, 2025, at 11:28 a.m. revealed that the resident was using a fully enclosed Posey Net Bed.Review of manufacture recommendation for Posey Bed revealed that the Posey Bed is a restraint, and must be prescribed by a licensed physician, for use only in healthcare facilities. Improper use of the Posey Bed 8070/8075 may lead to serious injury or death. Patient monitoring should be determined by hospital protocol, a doctor, and the patient care plan. The Posey Bed 8070/8075 is a hospital bed, canopy and mattress system designed to help provide a safe, controlled environment for patients at extreme risk of injury from a fall or unassisted bed exit. The Posey Enclosure Bed is intended to provide a safe, controlled environment for patients at risk of injury from unassisted bed exit or at risk of injury to self or others.Further review of the recommendation revealed that Proper training in the use of the Posey Bed 8070/8075 is required and is provided by your authorized Posey Bed dealer.A request for competencies and skill sets related to the care for residents with Posey Net Restraint Bed was made to the facility administration on July 31, 2025, for nursing staff Employee E13, E16 and E17 who provided care of residents.Facility did not submit staff education, competencies and skill sets related to the care for residents with Posey Net Restraint Bed.Interview with the Director of Nursing, Employee E2, on July 31, 2025, at 3:00 p.m. confirmed that there was no documentation available to show that licensed nursing staff, Employee E13, E16 and E17, had proper training and competencies related to the care for residents with Posey Net Restraint Bed. Review of Resident R59's clinical record revealed that Resident R59 was admitted to the facility on [DATE] Review of facility competency on Medication administration-through a feeding tube #5. Checks tube for placement, and patency prior to administration of meds. 4 with diagnoses of but not limited to Acute and Chronic Respiratory Failure and Gastrostomy status. Review of physician's orders revealed an order for: NPO (nothing by mouth) diet NPO texture, NPO consistency, Maintain NPO status at all times. dated June 25, 2025.Medication administration observation conducted with licensed nurse Employee E4 on July 30, 2025, at 8:57 AM revealed that during medication administration for Resident R59 Resident R59, Employee E4 proceeded to administer Resident R59's medication via gastrostomy tube using a large syringe via gravity without checking for placement of the gastrostomy tube. Further, Employee E4 did not have a stethoscope with her during medication administration.Interview with Employee E4 conducted at the time of the observation revealed she pushed air but she did not use a stethoscope. Further, Employee E4 revealed that she can hear without stethoscope. Further interview with Employee E4 revealed that her stethoscope was in the medication cart.Inspection of the med cart after medication administration revealed that there was no stethoscope in the med cart. Interview with Employee E4 confirmed that there was no stethoscope in the medication cart.Interview with facility administrator conducted on July 31, 2025, at 1:23 PM revealed that the facility did not have records of Employee E4's competency on medication administration which included medication administration through a gastrostomy tube. Further Employee E1 also revealed that the staff educator was the assistant director of nursing who left in April 2025. 28 Pa Code 201.20(b) Staff development.28 Pa Code 201.20(d) Staff development

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on the review of facility documentation, review of personnel files and interview with staff, it was determined that the facility failed to complete performance review of every nurse aide at least once every 12 months for five of five employees reviewed. (Employees E18, E19, E20, E21 and E22)Findings include:A request was made to the facility Nursing Home Administrator and Director of Nursing for annual training records for five Nurse Aides, Employees E18, E19, E20, E21 and E22 on July 31, 2025.Facility did not performance evaluation record for Employees E18, E19, E20, E21 and E22.Interview with the facility Administrator on July 31, 2025, at 3:00 p.m. confirmed that did not have performance evaluation of Employees E18, E19, E20, E21 and E2228 Pa. Code 201.18(b)(1)(3) Management28 Pa. 211.12(c) Nursing services

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on clinical record review, and staff interviews it was determined that the facility failed to ensure each resident is provided with the necessary behavioral health care in a timely manner to attain or maintain the highest practicable mental and psychosocial well-being for one resident of 13 resident records reviewed (Resident 46).Findings Include: Review of Minimum data set assessment (MDS-periodic assessment of resident's care needs), dated July 10, 2025, indicated that resident had a BIMS (Brief Interview for Mental Status-a screening assessment to aid in in determining cognitive impairment) score of 0 that indicated that resident's cognitive status was severely impaired. Review of clinical record for Resident R46 dated July 16, 2025 revealed that the resident noted to be yelling out a times, yelling at staff at times, as needed meds given, effective for about 3 hours, resident continue to yell out at times, offered to sit in chair, resident refuse, repositioned, refuse to allow staff to place helmet on head, continue to be educated on the importance of having helmet in place continue to refuse, nurse practitioner made aware, resident with new order for psych consult. new order for Seroquel 12.5mg (Antipsychotic Medication) twice daily until seen by psych Further review of the clinical record revealed that the resident did not have a documented diagnosis of schizophrenia, psychosis, bipolar or major depressive disorder which was the FDA (Food and Drug Administration) approved diagnosis for the use of Seroquel. Review of physician progress note dated July 17, 2025, revealed that the resident was started on low dose Seroquel for anxiety, needed psych follow up, staff was aware. Review of physician progress note dated July 18, 2025, revealed that the resident was on low dose Seroquel for anxiety, needed psych follow up, staff was aware. Review of physician progress note dated July 21, 2025, revealed that the resident was on low dose Seroquel for anxiety, needed psych follow up, staff was aware. Review of physician progress note dated July 22, 2025, revealed that the resident was on low dose Seroquel for anxiety, needed psych follow up, staff was aware. Review of physician progress note dated July 23, 2025, revealed that the resident was on low dose Seroquel for anxiety, needed psych follow up, staff was aware. Review of physician progress note dated July 25, 2025, revealed that the resident was on low dose Seroquel for anxiety, needed psych follow up, staff was aware. Review of physician progress note dated July 28, 2025, revealed that the resident was on low dose Seroquel for anxiety, needed psych follow up, staff was aware. Review of clinical record for Resident R46 dated July 29, 2025, revealed that the resident was non-compliant with wearing helmet and throwed helmet to the floor when applied. Review of physician progress note dated July 29, 2025, revealed that the resident was on low dose Seroquel for anxiety, needed psych follow up, staff was aware. Further review of clinical record for Resident R46 dated July 29, 2025, revealed that the resident was yelling out and crying in discomfort and as needed narcotic pain medication was given. Review of clinical record revealed that the resident was not provided by psychiatric consultation as ordered by the physician. Interview with director of nursing, Employee E2 on July 31, 2025, at 2 p.m. confirmed that the resident was not seen by psychiatric services and should have been seen as soon as possible. Employee E2 stated she did not have a date when the resident would be seen by the psych. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon review of clinical records, facility's pharmacy reviews, and policy it was determined the facility failed to act upon the irregularities noted by the pharmacist in a timely manner for four of 14 resident records reviewed (Residents R2, R4, R7, R8). Findings include:Review of the facility's Pharmacy Consultant Policy and Procedures, undated, states the Consult Pharmacist evaluates the residents' medication orders and submits a report to the Nursing Home Administrator and Director of Nursing which the facility has seven days to implement the pharmacist recommendation. Resident R2 was admitted to the facility on [DATE], with physician orders, dated April 15, 2025, for 0.5 milligrams (mg) of Clonazepam, instructed to give 1mg every 12 hours as needed for anxiety.Review of Resident R2's pharmacy review revealed on April 16, April 29, May 27, and June 24, 2025, indicated the order duration must be specified for a PRN (as needed) psychoactive medications and that the first order is limited to only 14 days. The review continues to say the duration may be for longer if rationale is documented by the prescriber to continue the order and requested to please update the order for Clonazepam. Further review revealed this was not addressed until, July 9, 2025.Review of pharmacy review for Resident R4 on April 29, 2025, revealed that missing indication for moderate pain with current PRN (as needed) pain orders. Please clarify or update orders so that all levels of pain are covered.Review of pharmacy review for Resident R4 on May 28, 2025, revealed that missing indication for moderate pain with current PRN (as needed) pain orders. Please clarify or update orders so that all levels of pain are covered.Review of pharmacy review for Resident R4 on June23, 2025, revealed that missing indication for moderate pain with current PRN (as needed) pain orders. Please clarify or update orders so that all levels of pain are covered.Review of pharmacy review for Resident R4 on July 25, 2025, revealed that missing indication for moderate pain with current PRN (as needed) pain orders. Please clarify or update orders so that all levels of pain are covered.It was revealed that the recommendation made by the pharmacist in April, May June and July 2025 was not addressed. There was no PRN pain medication for moderate pain as recommended by the pharmacist.Resident R7 was admitted to the facility on [DATE], diagnosed with generalized idiopathic epilepsy and epileptic syndrome, not intractable, without status epilepticus (neurological brain disorder). and anxiety disordered.Resident R7 was ordered 0.5mg of Lorazepam, instructed to give one tablet every 8 hours as needed for anxiety dated April 8, 2025.Review of Resident R7 pharmacy reviews dated, April 29, May 27, June 24, and July 25, 2025, indicated that a duration must be specified for PRN psychoactive medications. First order is limited to only 14 days. The duration may be for longer if rationale is documented by the prescriber to continue the order and requested to update the order for Lorazepam. Further review revealed this was not addressed until July 31, 2025.Review of Resident R7's physician orders, dated March 28, 2025, instructions to give 1 mg of Doxazosin Mesylate Tablet (alpha-blocker medication) daily, and Valproic Acid Oral Solution (an anticonvulsant medication) 250mg/5ml to give 5 ml enterally in the morning.Findings noted by the consult pharmacist stated on April 29, May 27, and June 24, 2025, asked to clarify and update the diagnosis for Doxazosin and Valproic Acid that was not corrected by the facility until July 9, 2025.Resident R8 was admitted to the facility on [DATE], diagnosed with general anxiety disorder. Physician order, dated June 27, 2025, instructed to give 0.5mg of Alprazolam oral tablet every 12 hours as needed for anxiety. 0.5 mg. Review of Resident R8's pharmacy review indicated a duration must be specified for PRN psychoactive medications. First order is limited to only 14 days. The review continues to say the duration may be for longer if rationale is documented by the prescriber to continue the order and requested to please update the order for Alprazolam. Further review revealed this was not addressed until July 31, 2025.28 Pa. Code 211.12(d)(1) Nursing services

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, review of clinical record, interview with staff, and review of facility policy, it was determined that the facility failed to ensure that medications and biologicals are labelled and stored in a safe and secure manner for medication storage areas in two of two nurses' stations observed. (West and East side nurse stations) Findings include: Review of facility policy on Storage of Medications section Policy Statement revealed that AristaCare at East Falls shall store all drugs and biologicals in a safe, secure, and orderly manner. Under section Policy Interpretation and Implementation #3. Drug containers that have missing, incomplete, improper or incorrect labels shall be returned to the pharmacy for labelling before storing. #4. AristaCare at East Falls shall no use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. #7. Compartments (including but not limited to. Drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be a locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.Observation of the nurse's station west side nurse's station conducted on July 28, 2025, at 10:42am with licensed nurse Employee E7 revealed that that the nurse's station was unattended. Further observation revealed a medication refrigerator was under the counter of the nurse's station. Further observation revealed that the refrigerator was not locked. Observation of the content of the refrigerator revealed multiple vials of Unopened Lantus 100 units/ml-no label, multiple vials of Lispro 100 u/ml 10 ml unopened- no label, Novolin. Further observation of the content of the refrigerator revealed one opened Purified Protein Derivative tuberculin. Box containing one open vial of opened Purified Protein Derivative tuberculin. Further the vial did not have an open date. Review of instruction on the box revealed that vial should be discarded 30 days after opening.Further observation revealed one unopened vial of Influenza vaccine-Afluria exp-June 30, 2025.Observation of the nurse's station counter revealed 8 Bag of 100 ml 0.9% NaCl (sodium chloride)Further observation revealed multiple intravenous fluid in a plastic bin on top of counter in nursing station, Meropenem for injection 1gm/ vial, and Ertapenem 1gm/vial labelled with Resident R1's name on the counter of the nurse's station.Interview with Employee E7 conducted at the time of the observation confirmed the above observation.Observation of the east nurse's station conducted on July 30, 2025, at 8:47AM with Director of Nursing (DON), Employee E2 revealed Plastic bag labelled vancomycin 1gm/250 ml inside were -5 vials of Vancomycin 1 gm/vial plus 6 vials Vancomycin 1 gm/vial. Further observation revealed that the medication refrigerator located under the counter in nurses station east was not locked medications were inside.Interview with Director of Nursing, Employee E2 conducted at the time of the observation confirmed that medications were left unattended on top of the counter in the nurse's station and the medications was unlocked. Further interview with the DON Employee E2 revealed that medications should be stored in locked cabinets.28 Pa. Code 211.12(c) Nursing services

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	07/31/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview with staff and review of facility policy, it was determined that the facility failed to maintain an effective infection control program to prevent the development and transmission of communicable diseases for one of one resident observed for tracheostomy care. (Resident R54)Findings include:Observation of Resident R54 during Tracheostomy care observation conducted June 30, 2025, at 10:46 with Employee E8 revealed that EmployeeE8 prepared the tracheostomy care materials by placing placed a paper towel on top of the bed, proceeded to put clean, gauzes and all the supplies on top of the paper towel. Started suctioning, started cleaning the stoma with gauze taken from on top of the paper towel, placed the used gauze back on the paper towel on top of the clean items, proceeded to pick up gauze from the paper towel and placed them on the paper towel together with clean items-dirty gauze on top of clean gauzeInterview with Licensed nurse, Employee E8 conducted at the time of the observation confirmed that he placed dirty gauzes on top of clean treatment items during respiratory care.28 Pa. Code 211.10(d) Resident care policies28 Pa. Code 211.12(d)(1) Nursing services