STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39A435	A. Building B. Wing	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southeastern Pennsylvania Veteran's Center	One Veterans Drive Spring City, PA 19475

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy and procedure review, staff and resident interviews, facility documentation review, and clinical record review it was determined the facility failed to ensure that one of 55 residents was free from neglect during care resulting in actual harm causing skin laceration, subdural hematoma, and cervical fractures requiring hospitalization. This deficiency is cited as past noncompliance. (Resident 1) Findings Include: Review of facility policy and procedure titled, Freedom form Abuse, Neglect Exploitation and Misappropriation revised May 7, 2025, revealed the definition of Neglect as the failure of the home, its employees or service providers to provide goods and services to a resident that are necessary to avoid physician harm, pain, mental anguish, or emotional distress. Review of Resident 1's face sheet revealed a diagnosis of Hemiplegia (one-sided paralysis) and Hemiparesis (one-sided muscle weakness) following a cerebral infarction (blocked blood flow to brain) affecting left non-dominant side. Review of Resident 1's care plan dated February 20, 2025, and last revised May 29, 2025, revealed a care plan for ADL (Activities of Daily Living- basic tasks that individuals perform to maintain their daily life) with interventions that included therapy recommendations of bed mobility: assist x 2 (with two people) with side rails. Review of Resident 1's quarterly Minimum Data Set (MDS- periodic assessment of resident needs), dated May 15, 2025, revealed Resident 1 was dependent on 2 staff for rolling left and right in the bed. Review of Resident 1's hospital Discharge summary dated [DATE], revealed the resident sustained a closed displaced fracture of the first cervical vertebrae (ring shaped bone that begins at base of skull), closed displaced fracture of second cervical vertebrae, cervical compression fracture (small break in bones of spine), subdural hematoma (bleeding inside head), and laceration (skin tear) of the scalp. Review of Resident 1's Progress Notes revealed a nursing entry dated June 16, 2025, at 3:17 p.m. indicating, received call from staff at approximately 1350 (1:50 p.m.) for reports of resident fall needing stat (immediate) assistance. On arrival to unit resident on his/her left side on the floor on the left side of the bed. Unit nurse was present and applying direct pressure to left side head laceration. Provider was present on unit and provider ordered to transfer to ER (emergency room). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of facility investigation into the injury revealed a witness statement from non-licensed Employee E3 indicating, on Monday June 16, 2025 at 1:54 p.m., [Resident 1] fell out of bed on the floor between the bed and the window, I was changing his/her brief and had him/her all wiped clean but could not put a brief on him/her because his/her wound dressings were full of bowel movement, I looked for the nurse and could not find him/her. So, I go back in the room to find that Resident 1 had another really bad bowel movement. So, I'm trying to get him/her wiped clean again and he/she kept trying to roll on his/her back. I had all the soiled lines (linens) and dirty pad rolled under his/her right hip. He/she kept telling me their right hip hurt, and I was trying to work fast but he/she kept trying to roll on his/her back. Then there was loose bowel movement on the bed itself and I was trying to clean that up. A top sheet fell on the floor and that was when Resident 1 fell out of the bed. Further review of investigation documentation revealed an addendum to Employee E3's witness statement indicating, when the top sheet fell on the floor, I turned to my left to pick it up when the resident fell on the floor. When the resident fell off the bed onto the floor, I had turned away from the bed. Seven additional witness statements were reviewed but no additional witnesses to the fall were found. Review of information dated June 16, 2025 submitted by the facility to Department of Health on June 16, 2025, revealed at approximately 13:45 p.m. (aka 1:45 p.m.), Resident 1 was on the floor lying on his/her left side. Bleeding was noted from left side of head. Resident complaints of head pain and left hip pain. Resident on Eliquis (blood thinner) BID (2x daily) sent to ER (emergency room) for evaluation and treatment per provider. Employee E3 was noted to not be following the resident care plan 2 person assist for bed mobility. The bed was in a high position to provide incontinence care at the time of fall. The resident rolled while lying on his right side in the bed and landed on his left side on the floor. Neglect accusation substantiated. Interview on July 1, 2025 conducted with the Nursing Home Administrator (NHA) and Director Of Nursing (DON) when DON confirmed the resident rolled while lying on his/her right side in bed and landed on his/her left side on the floor. The NHA confirmed Employee E3 was found to not be following the resident care plan of two-person assistance with bed mobility. The facility initiated a plan of correction on June 16, 2025. Employee E3 received Education and retraining on following care plans for resident's bed mobility. All residents requiring two-person assistance for bed mobility and/or continence care were reviewed to ensure accurate information is listed on resident information sheets. Registered Nurse Instructors provided education to direct care staff of the importance of checking resident information sheets, how to follow information sheets, and where to find resident information sheets. Education was also provided on facility abuse and neglect policy and potential outcomes. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Quality Assurance Department designee will audit 10% of direct care staff four times per week for four weeks then two times per week for two months, to ensure staff are aware of the importance of checking resident information sheets, how to follow the information sheets and where to find the resident information sheet. Results of all audits will be reviewed at the Quality Assurance and Performance Improvement (QAPI) meetings. The Quality Assurance (QA) Committee will determine the need for additional audits and/or interventions for ongoing compliance. Review of facility Plan of Correction (POC) on July 1, 2025, revealed education titled bed mobility and the need for two-staff members initiated on June 20, 2025, and completed on July 1, 2025. The key factor was noted as fall preventions and resident safety. Review of facility POC revealed education titled Importance of Following Care Plans (Resident Information Paperwork) initiated on June 26, 2025, was completed on July 1, 2025. Key factors included the location of the care plan, what to do if not able to locate, information included on care plan and why it is important to follow the care plan. Further review of the POC education documentation titled Mechanical Lift Device Policy, initiated June 24, 2025, and completed on July 1, 2025. The purpose was noted as to provide guidance regarding enhancing residents quality of life with increased development of culture change to the best abilities possible. Review of facility POC revealed resident audits documenting 55 residents care planned for two-person assistance. Interviews conducted on July 1, 2025, confirmed nine nursing staff received the education on bed mobility, two-person assistance, care plans and mechanical lift device use. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services