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	05/09/2025

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 41765 Based on a review of the facility's policy, clinical records review, and staff interview, it was determined that the facility failed to timely notify the physician of a significant weight change for one of the 35 residents reviewed (Resident 63). Findings include: A review of the facility's policy titled Weight Policy, last revised on June 23, 2020, revealed routine weights will be done to monitor or detect any changes that would adversely affect the resident's health. A weight will be obtained upon admission and/or readmission, then weekly times four weeks. A weight loss or gain of 5% in one month will require a reweight. Dietitians will evaluate weekly weights and monthly weights to determine if additional interventions are needed. If there is a significant weight change, the Dietitian will notify the physician. A review of Resident 63's diagnosis list includes Congestive Heart Failure (CHF-A weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs), Chronic Kidney Disease (CKD-Gradual loss of kidney functions which can result in renal failure). A review of Resident 63's physician's order dated November 15, 2024, revealed an order to weigh the resident three times a week to monitor for weight gain due to edema. A review of the weights and vitals revealed a weight of 197 pounds on January 10, 2025, and a weight of 217 pounds on June 15, 2025, a 20 pounds (9.22%) weight gain in five days. Further review of the weights and vitals report revealed Resident 63 was not reweighed until January 20, 2025, five days after a significant weight gain was identified. Clinical records review failed to reveal that the resident was assessed upon identifying a significant weight gain. The record review also failed to reveal that the physician was notified of the significant weight gain until reported weight concerns on January 24, 2025. Interview with the Director of Nursing on May 6, 2025, at 10:00 a.m., confirmed physician was not notified of Resident 63's significant weight gain timely. The facility failed to ensure physician was notified of Resident 63's significant weight gain. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services Previously cited 6/14/24, 3/16/24

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 35913 Based upon review of facility policy and procedure, clinical record review, and staff interview it was determined the facility failed to follow physician orders for fluid restriction and administration of medication for one of one resident reviewed (Resident 52). Findings include: Review of facility policy and procedure titled Hydration Policy revealed Residents on fluid restriction will receive fluids as per Provider Order. Review of Resident 52's diagnosis list revealed diagnoses including congestive heart failure (CHF - excessive body/lung fluid caused by a weakened heart muscle), Diabetes Mellitus (DM - failure of the body to produce insulin to enable sugar to pass from the blood stream to cells for nourishment), urinary retention (bladder does not completely empty) and chronic obstructive pulmonary disease (COPD - disease process that causes decreased ability of the lungs to perform). Review of Resident 52's physician orders dated October 16, 2024, revealed 2000 cc Fluid Restriction. Total Dietary 680 cc, Total Nursing 1340 cc, (7-3 shift: dietary 480 cc, nursing 480 cc), (3-11 shift: dietary 180 cc, nursing 480 cc), (11-7 shift: nursing 380 cc). Review of Resident 52's Medication Administration Record (MAR) and the I/O (intake and output) Chart Detail Report, revealed the facility failed to follow the 2000 cc fluid restriction ordered by the physician for the following dates: April 11, 2025 - 2220 cc; April 12, 2025 - 2960 cc; April 13, 2025 - 2530 cc; April 14, 2025 - 2120 cc; April 15, 2025 - 2240 cc; April 16, 2025 - 2720 cc; April 17, 2025 - 2960 cc; April 18. 2025 - 2240 cc; April 19, 2025 - 2340 cc; April 21, 2025 - 2840 cc; April 22, 2025 - 2530 cc; April 23, 2025 - 2120 cc; April 24, 2025 - 2960 cc; April 27, 2025 - 2560 cc; April 28, 2025 - 2090 cc and April 29, 2025 - 2388 cc. Further review of Resident 52's physician orders revealed an order for Midodrine (medication used to treat low blood pressure) 5 milligrams (mg) three times per day and to hold the medication of the systolic blood pressure is greater than 120 mmHg (millimeters of mercury). Review of April 2025 MAR revealed on April 3, 2025, at 9:00 a.m. Resident 52 received Midodrine 5 mg for a blood pressure of 130/70 and on April 5, 2025, at 9:00 p.m. Resident 52 received Midodrine 5 mg for a blood pressure of 123/72. Review of May 2025 MAR revealed on May 4, 2025, at 1:00 p.m. Resident 52 received Midodrine 5 mg for a blood pressure of 128/70 and on May 4, 2025, at 9:00 p.m. Resident 52 received Midodrine 5 mg for a blood pressure of 125/64. Interview with the Nursing Home Administrator and Director of Nursing on May 9, 2025, at 10:00 a.m. confirmed that the facility was not following physician orders for fluid restriction or medication administration for Resident 52. 28 Pa. Code 211.12(d)(1)(2) Nursing Services (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Previously cited 6/14/2024

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 41765 Based on observation, review of the facility's policy and procedures, facility documentation, clinical records, and staff interviews, it was determined the facility failed to ensure direct care staff were educated on the safe food heating/reheating process. This failure resulted in Immediate Jeopardy situation when it was determined a licensed nurse whom the facility failed to educate regarding safe food heating protocol failed to check the temperature of ramen soup after heating it in a microwave resulting in Resident 78 sustaining a second-degree burn to the chest. Failure of the facility to provide education to all direct care staff regarding safe food heating resulted in a situation that jeopardized the health and safety of Resident 78. This was identified as a past non-compliance situation. Findings include: Review of the facility's policy titled, Dietary Services: Food Palatability/Re-heating revision date of [DATE], revealed it is the policy of the facility, meals are prepared and readied at proper (safe and appetizing) temperature, meaning both appetizing to the resident and minimizing the risk for scalding burns. Further review of the same policy revealed food/beverages will be heated, stirred, temped (temperature taken), stirred again, and re-temped before delivery: Ensure no hot spots are in the food/beverages by stirring The temperature of the food/beverages will be taken before delivering the item to the resident; Temperatures of any hot food/beverage items, such as commercially processed and packaged ready-to-eat foods are at least 140 F and not exceed 165 F. Review of Resident 78's diagnosis list included Diabetes (group of metabolic disorders characterized by a high blood sugar level over a prolonged period), and Peripheral Vascular Disease (PVD-circulatory condition that affects blood vessels outside the heart and brain, particularly in the legs and arms). Review of Resident 78's Quarterly Minimum Data Set (MDS- standardized assessment tool that measures health status in long-term care residents) dated February 5, 2025, revealed Resident 78 was cognitively intact and had no impairments of the upper extremities. Review of the Occupational Therapy (type of rehabilitation therapy that focuses on helping people perform the tasks necessary for daily life) progress notes dated [DATE], revealed Resident 78 requires set-up assistance with feeding/eating. Observation conducted on [DATE], at 10:00 a.m., revealed Resident 78 lying in bed without a shirt. A light red mark was observed on the resident's chest and abdomen. Interview with Resident 78 conducted on [DATE], at 10:00 a.m. revealed, Resident 78 reported a few weeks ago, at nighttime (unable to provide exact date and time), he/she requested staff prepare him/her a cup of instant ramen noodle soup. The staff delivered the soup overfilled with hot water, enough that when he/she grabbed the cup, the soup spilled onto his/her chest which resulted in a burn. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the nursing progress notes dated [DATE], at 10:08 p.m., revealed staff reported at approximately 4:30 p.m., the resident spilled soup on his/her chest area. The resident was noted with an intact reddened area measuring 12 x 15 cm. (centimeters) to the upper chest. The resident stated he/she was eating the noodle soup and some of it spilled on the chest. Review of the NP's (Nurse Practitioner) notes dated [DATE], at 10:15 a.m., revealed resident was seen for chief complaint of burn/pain. Resident indicated, yesterday, one of the girls heated up my soup and there was more water in there than I was expecting so when I went to eat it, I spilled it on my chest. The resident complained of pain immediately but indicated area no longer painful unless it was touched. The NP ordered a treatment of Silvadene (medication used to treat burns) to the burn area and wound consult. Review of the wound care consult dated [DATE], at 12:02 p.m., revealed resident was seen to assess mid chest post burn. The same consult revealed resident had a second-degree burn (damage to the outer layer of the skin and the underlying layer) measuring 12 x 12 cm field to the upper mid-chest and a 5.0 x 5.0 cm field inferior to the larger burn site. An order to continue the Silvadene to the burn area was initiated. Review of the facility's investigation, revealed a statement from licensed nurse Employee E3 indicating: At 4:30 p.m., I heated up a cup of noodles and some other food for [resident]. I brought the soup to him/her and left (room) to finish heating the rest of his/her food. When I returned to his/her room, his/her soup was all over him/her. I asked him/her what happened, (resident) said he/she spilled it on him/herself. His/her shirt was wet, and I asked him/her if I could remove it to look at his/her skin then I went to get the nurse. Review of clinical records and facility documentation failed to reveal documented evidence of food temperatures taken by Employee E3 indicating Employee E3 did not followed the facility's policy of safe food/beverages heating/reheating by not checking the soup temperature before serving the cup of ramen noodle soup to Resident 78. Interview with the Nursing Home Administrator (NHA) conducted on [DATE], at noon, confirmed Employee E3, served Resident 78 the noodle soup without checking its temperature. The Nursing Home Administrator confirmed Employee E3 did not follow the facility's policy regarding the safe heating of the food/beverages. Further interview with the NHA revealed that all direct care staff which includes nurses and nursing assistants were not educated/trained regarding the facility policy and procedure on safe food/beverages heating/reheating to prevent burns. An Immediate Jeopardy situation was identified on [DATE], at 1:36 p.m. and the Immediate Jeopardy template was presented to the NHA, regarding the facility's failure to ensure all direct staff were educated/trained on safe food/beverages heating/re-heating to prevent burns to the residents. The facility submitted and completed an immediate action plan on [DATE], and was accepted on [DATE], at 2:54 p.m. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facily's immediate action plan included the following: Education was provided to the staff (Employee E3); A whole house audit was conducted to check all microwaves in the facility had thermometers attached to it; All residents were assessed to ensure no other residents received a burn from re-heated food items; Process signage for re-heating food in the microwave were attached to the microwaves; House-wide education developed and implemented for all facility staff on re-heating process, education was implemented and presented during the new hire and agency orientation; Dietary performed audits to ensure thermometers are present and functioning on all microwaves in resident areas; Audits were completed and ongoing time a week for four weeks, then every other week times four; The outcome of audits will be reviewed at the QA meeting. The facility self identified the jeopardy at the time of the incident, [DATE]. The facility implemented a corrective action of education, whole house assessments, and monitoring audits. On [DATE], after review of audits and documentation of completed employee education as well as interviews with 20 staff members revealed the facility had completed the interventions developed for the action plan on [DATE]. The Immediate Jeopardy was lifted on [DATE], at 11:12 a.m., after confirmation the action plan was implemented and completed. The Nursing Home Administrator and the Director of Nursing were informed the residents were no longer in immediate jeopardy with Immediate Jeopardy lifted. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management Previously cited [DATE] 28 Pa. Code 201.18(e)(3) Management 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services Previously cited [DATE], [DATE], [DATE]

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 41765 Based on clinical records review and staff interview, it was determined that the facility failed to ensure medications necessary for residents with kidney disease were administered as ordered for one of the two residents reviewed (Resident 46). Findings include: A review of Resident 46 diagnosis list includes End Stage Renal Disease (ESRD- Where kidney function has declined to the point that the kidneys can no longer function on their own). Clinical records review revealed resident goes to Dialysis (A process of purifying the blood of a person whose kidneys are not working normally) every Monday, Wednesday, and Friday, pickup time at 9:30 a.m. A review of Resident 46 physician's order dated November 9, 2025, revealed an order for Renvela (A medication used to control phosphorus levels for people with chronic kidney disease) 800 mg two tablets three times a day. The medications were scheduled at 8:00 a.m., 12 noon and 5:00 p.m. A review of the April 2025, Medication Administration Record revealed Renvela's medication was not administered at 12 noon on the following dates: April 2, 14, 16, 21, 23, 25, 28, and 30, 2025. The MAR documentation revealed medication not administered- Resident unavailable. Clinical records review failed to reveal Resident 46's physician was notified of the missed medications. An interview conducted with the Director of Nursing (DON) on May 6, 2025, at 10:00 a.m., confirmed that Renvela medication was not administered due to the resident being out of the facility for Dialysis. The DON also confirmed that the physician was not notified of the missed medications. The facility failed to ensure that ordered medications were administered to a resident on Dialysis. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services Previously cited 6/14/24, 3/16/24

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 41765 Based on a review of job descriptions, clinical records, it was determined that the Commandant and Director of Nursing did not effectively manage the facility to make certain that all direct staff were educated and trained with facility's policy and procedure regarding safe heating/re-heating of food and beverages to prevent resident from getting burns. Findings include: A review of the job description of the Commandant revealed the following: Responsible for managing and controlling all health-related activities and management functions of the facility; Establish and maintain a safe environment for residents and staff by operating safety programs that is in conformance with agency, state, and federal standards to protect the health and safety of the residents. A review of the job description of the Director of Nursing revealed the following: Directs all nursing care activities and participates in the administration of the multidisciplinary and non-clinical aspects of the resident's extended care facility's overall operation; In conjunction with multidisciplinary team, plan, direct, administer, coordinate, monitor, and evaluate facility-wide operations affecting health services; and Maintain current knowledge of developments in the field of nursing and communicate rules and regulations, facility and department policies and procedures to nursing staff by explaining and interpreting and ensure understanding and proper implementation and observance of these matters. Analyzes and evaluates long term care nursing operations to ensure compliance with applicable regulatory agency standards and requirements. Based on the findings in this report that identified that the facility failed to ensure education and training were provided to all direct care staff regarding safe food and beverages heating which placed residents in Immediate Jeopardy. The Commandant and the DON failed to fulfill their essential job duties to ensure that the federal and state guidelines and regulations were followed. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 207.2(a) Administrator's responsibility. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.