STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395134	A. BLDG: 00 B. WING:	08/01/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
INGLIS HOUSE STATE LICENSE NUMBER: **090202**	**2600 BELMONT AVENUE** **PHILADELPHIA, PA 19131**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on an Abbreviated Survey in response to a reportable incident, completed on August 1, 2025, it was determined that Inglis House, was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations, related to the health portion of the survey process.	F 0000		
F 0689 SS=J	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 0689	Past noncompliance: no plan of correction required.	Completion Date: **08/22/2025** Status: **APPROVED** Date: **08/28/2025**

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0689 SS=J	Continued from page 1 This REQUIREMENT is not met as evidenced by:	F 0689		

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F 0689 SS=J	Continued from page 2 Based on observations, review of clinical record, facility policies, facility documentation, and interviews with staff, it was determined the facility failed to adequately supervise one of five residents reviewed (Resident R1). This failure resulted in Resident R1 wandering in the hallways of the facility on an electric wheelchair, and accessing the fire stairway entrance door, falling down a flight of stairs while strapped to the wheelchair. Resident R1 was missing for a period of approximately four hours after the fall. Resident R1 required transfer to the hospital and diagnosed with rib fractures, a fracture of the right clavicle, a subdural hematoma and closed dislocation of left finger and five stiches to the right top of the head. This deficiency was identified as Immediate Jeopardy Past Noncompliance. (Resident R1) Findings include: Review of facility policy titled, "Elopement" dated February 15, 2000, revealed the facility's protocol	F 0689		

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F 0689 SS=J	Continued from page 3 and guidelines to follow when a resident cannot be located. Continued review revealed, "Residents who have been assessed, determined not to be safe in the community alone, and have been identified as a risk for elopement are not permitted to leave the campus alone. This policy outlines procedures to be implemented when it is determined that a Resident: identified as an elopement risk has attempted to elope or is " missing " from Inglis." " An elopement risk assessment is conducted upon admission, quarterly, upon identification of a possible risk, and after an attempted or actual elopement. Resident assessed as an elopement risk will have an appropriate care plan implemented." " Elopement is a term used to describe an incident when a Resident, who has been assessed to be unsafe in the community alone, physically leaves the campus, or is observed attempting to leave the campus, or has not returned from an unauthorized leave or trip. Elopement can be intentional or unintentional." " Roam Alert is a system that provides protection to wandering-prone residents by controlling exit doors. When the resident approaches a door, the system	F 0689		

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F 0689 SS=J	Continued from page 4 alerts Security to act. The Roam Alert System provides freedom of mobility to Residents in Long Term Care Facilities, while ensuring that they remain safe." Review of Resident R1's admission documentation revealed the resident was admitted to the facility on June 7, 2023, with diagnoses including Bipolar Disorder (mental health condition characterized by extreme shifts in mood, energy, and activity levels, cycling between periods of high and low and can significantly impacting a person's ability to function in daily life), and Dementia (group of symptoms affecting memory, thinking and social abilities.) Review of Resident R1's Elopement Evaluation, dated July 22, 2022, revealed that the resident was assessed by the facility to be at risk for elopement. Review of Resident R1's Quarterly MDS (Minimum Data Set - mandatory periodic resident assessment tool), dated May 14, 2025, revealed the resident was admitted to the facility on June 7, 2023, and	F 0689		

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F 0689 SS=J	Continued from page 5 with a diagnosis of Multiple sclerosis (chronic, often disabling disease that attacks the central nervous system-brain and spinal cord. It's an autoimmune disease, meaning the body's immune system mistakenly attacks its own tissues). Continued review revealed the resident had a BIMS (Brief Interview for Mental Status) score of five, which indicated the resident was severely cognitively impairment. Further review of the MDS revealed that the resident required Extensive Assistance for transfer. Review of Resident R1's care plan, initiated June 8, 2023, revealed that Resident R1 was an elopement risk related to disorientation to place, and due to impaired safety awareness; with interventions of Wander Alert, (safety device placed on resident which alarms/lock doors to the outside of the building), check for placement as per orders, air tag (tracking device designed to act as a key finder, which helps people find personal objects), monitoring when out of bed; and education to staff on ensuring resident does not enter restricted area	F 0689		

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F 0689 SS=J	Continued from page 6 (Morris Building, staff rooms, medical supply rooms, maintenance rooms, mechanical rooms, kitchen/food services areas, corporate offices). Revision date as July 3, 2025. Review of Risk Elopement Evaluations dated January 15, 2025, and May 11, 2025, for Resident R1 revealed Resident R1 was at risk of elopement. Review of clinical notes for Resident R1 revealed a hospice care note, dated July 18, 2025, at 6:53 a.m., indicated "Resident in bed, slept well through the night, no apparent distress, no complaint of pain or discomfort, will monitor." Review of clinical notes for Resident R1 revealed a nursing note, dated July 18, 2025, at 3: 19 p.m., indicated "Resident out of bed to wheelchair at this time." Review of clinical progress notes for Resident R1 revealed a nursing note, dated July 19, 2025, at 12:13:00 a.m., indicated " at 10:22pm, NHA	F 0689		

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F 0689 SS=J	Continued from page 7 (Nursing Home Administrator) and DON (Director of Nursing) called and spoke to resident's wife RP (Responsible Party) about resident missing after dinner, and facility staff search each room and facility ground. Wife stated that she came in visit him today in the afternoon, left him in the room at 3:30 pm." Review of documentation submitted to the State Survey Agency on July 19, 2025, revealed that on July 18, 2025, " [Resident R1] was admitted to Inglis House on June 7, 2023 with a BIMS of 7, alert to name only. Resident is able to communicate needs. [Resident R1] non ambulatory, is able to use (his/hers) upper extremities, utilizes (his/her) power wheelchair for mobility, and is independent with locomotion. (He/She) was found in stairwell, ... around 11pm." " [Resident R1] finished a visit with (his/her spouse) around 3:30, (spouse) left (him/her) in (his/her) room to watch TV. (He/She) finished dinner around 5:45pm, video indicated that (he/she) was seen going down the hallway of 3 North towards the therapy side of the building. (He/She)	F 0689		

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F 0689 SS=J	Continued from page 8 continued through the double doors, to the next set of doors leading to the stairwell. " Stat 555 was called to the Morris Klein side of the building, resident was observed on the floor with (his/her) head in an upward position, and (his/her) wheelchair positioned behind (him/her). Resident was alert, seatbelt fastened, and from the knee up (he/she) was positioned on the landing of the staircase. Several male staff members including the RN supervisor, lifted (him/her) and chair in the upright position. Resident was sent out to Hospital for further evaluation." (Spouse) was made aware. Physician and hospice were notified ... [Resident R1] returned on Monday July 21st with a diagnosis of fall: Pneumothorax on the right, rib fractures 2-3-4, fracture of the right clavicle and subdural hematoma. Resident is negative for shortness of breath, chest pain, nausea and vomiting and Per family and (spouse) no medical or surgical interventions required. Resident is at baseline for mental status and resumed Hospice upon re-admission. (He/She) was re-admitting to a new room on the first floor across from the nursing	F 0689		

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F 0689 SS=J	Continued from page 9 station, and when out of bed (he/she) will be using a manual wheelchair. " During an interview on July 30, 2025, at 1:16 p.m., Employee E3, a Registered Nurse, who was the Nurse Supervisor for 1st, 2nd, and 3rd Floor North Side, at the time of the incident happened confirmed that on July 18, 2025, Resident R1 was in the dining room between 5:30 p.m.- 5:45 p.m. After dinner, before 8:00 p.m., Resident R1 was seen over 3 South, at the end of the hall and was instructed to return to (his/her) unit 3 North. At 8:00 p.m. Nurse Supervisor, Employee E3 was on the unit and staff informed Employee E3 that Resident R1 was nowhere to be found. Resident R1 is known to wander to different rooms, and the staff started to look on 3 North in all the rooms for Resident R1. Staff were not able to find Resident R1 on the 3rd North. Employee E3, called Security to overhead page for Resident R1 to return to (his/her) room. At 9:00 p.m. Employee E3 called the other supervisor to notify her that the staff could not find Resident R1, and to have her units look in all their rooms,	F 0689		

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F 0689 SS=J	Continued from page 10 elevators, shower rooms for the resident. At 9:45 p.m. Registered nurse, Employee E3 called the Nursing Home Administrator (NHA) and Director of Nursing (DON) to notify them Resident R1 was nowhere to be found in the facility. Resident R1 had a Roam alert and Security stated that it did not go off or show that he/she had exited externally from the building. The search for Resident R1 continued to the internal portion of the courtyard and other areas of the building. At 10:28 p.m. the DON arrived, and staff had completed the check of all common areas, parking lot, courtyard, elevators, stairwells, and accessible areas of the business office that would be accessible for Resident R1. At 10:30 p.m. staff went to the business office side to check areas that Resident R1 would not normally be accessible to. A code was entered to go into the internal business office area on the third floor. Staff looked in the area and continued to the back stairwell of that area. At 10:45 p.m. Resident R1 was found by the , Environmental Service Director, Employee E14, on the landing at the bottom of the	F 0689		

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F 0689 SS=J	Continued from page 11 first set of steps. Interview with the DON on July 30, 2025, at 1:30 p.m. also confirmed the above information with date and times. On July 30, 2025, at 11:41 a.m., interviewed the Director of Engineering Services, Employee E4, along with Assistant Nursing Home Administrator (ANHA), Employee E1, and Director of Nursing (DON) , Employee E2, showed the route the resident took on July 18, 2025 starting from the Third Floor Therapy Area hallway leading to Morris Hall Vestibule; at the beginning of Morris Hall office there is a door; which was left open accidently; there was no wanderguard detector (alarm mechanism which locks/alarms) on the door, as it was not part of resident area. ANHA, Employee E1, and DON, Employee E2 reasoned that Resident R1 moved forward in his/her wheelchair, pushed open the door at the fire stairway entrance door; and fell with his/her wheelchair below approximately eight small steps.	F 0689		

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F 0689 SS=J	Continued from page 12 Interview conducted on July 30, 2025, at 12:27 p.m., with Resident R1, revealed Resident R1 was in his/her bed, with pleasant expressions. Resident R1 stated did not remember the accident that he/she sustained. On August 1, 2025, at 11:24 a.m., interviewed Employee E14, Environmental Service Director, who found Resident R1, on July 18, 2025, at 10:45 p.m. Employee E14 stated that he found Resident R1 on the floor with (his/her) head in an upward position, and resident's wheelchair positioned behind him/her. Resident was alert, seatbelt fastened, and from the knee up resident was positioned on the landing of the staircase. Reviewed of Resident R1's hospital records revealed the resident was " Admitted on July 19, 2025, from Nursing Home for fall on July 18, 2025, down flight of stairs who at baseline uses wheelchair due to right sided paralysis. Multiple injuries, including PTX (pneumothorax, a condition where air	F 0689		

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F 0689 SS=J	Continued from page 13 leaks into the space between the lung and chest wall, causing the lung to potentially collapse) with rib fractures 2-4, SDH (Subdural Hematoma- a condition where blood collects between the dura mater and arachnoid layers of the brain's protective coverings), right clavicular (the collarbone) fracture, left fourth digit (finger) dislocation, scalp hematoma (a collection of blood under the skin of the scalp, often appearing as a bump on the head), and multiple abrasions (a superficial skin injury caused by rubbing or scraping against a surface)...Admitted to trauma floor." Review of facility nursing progress note dated July 22, 2025, indicated the resident was readmitted to the facility at 12:30 p.m. Resident was awake and responsive, verbalizing needs without problems. The admitting diagnoses included "Trauma, closed dislocation of left finger, multiple rib fractures, Fracture of right clavicle, subdural hematoma ... 5 stitches to (right) top of head, bruise to (R) shoulder, red bruise to (left) side scalp, bruise to (R) side face, swelling to (R) hand, scab to (R) and (L)	F 0689		

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F 0689 SS=J	Continued from page 14 shin, chest tube puncture site to (R) side, abrasion to (L) shoulder, intact blister to (L) upper arm, scab to (R) outer ankle, splint to (R) finger, dressing intact." Based on the above findings, an Immediate Jeopardy for the safety of the resident was identified for failure to provide adequate supervision of resident with dementia who was known to be at risk for elopement. The resident went missing on July 18, 2025, at 5:55 p.m. and was not located until July 18, 2025, at 10:45 p.m., a period of almost more than four hours. An Immediate Jeopardy template (a document which included information necessary to establish each of the key components of immediate jeopardy) was provided to the Nursing Home Administrator (NHA) and Director of Nursing (DON) on July 31, 2025, at 10:22 a.m. On July 31, 2025, at 5:10 p.m. the facility's action plan was accepted. The action plan included the following: 1. Assess the safety of residents utilizing power	F 0689		

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F 0689 SS=J	Continued from page 15 wheelchairs. · Facility assessment for resident safety with use of power wheelchairs was completed on July 21, 2025. Facility identified five residents that are at potential at risk based on the completed audit. (Completed on July 21, 2025) · Resident R1 was assessed upon his return from hospitalization by rehabilitation services, based on assessment Resident R1 was set up for manual wheelchair for safety as of July 23, 2025. 2. Ensure all doors are locked to non-resident areas. · As part of this facility investigation, identified doors to non-residential areas have been secured. Facility completed the following measures to ensure resident safety. · Set up of keypad lock to Morris Building to limit resident access to non-residential area.	F 0689		

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F 0689 SS=J	Continued from page 16 (Completed on July 19, 2025) · Education of staff that was responsible for non-compliant with security door process. (Completed on July 19, 2025) · Updated security process to monitor and audit identified doors to non-residential areas to ensure resident safety (Process effective July 26, 2025). 3. Revise/ review resident safety policies to include power wheelchairs, locked doors, stairwells, and elopements. · Facility review of resident safety policy initiated on July 26, 2025. 4. Ensure development of care plan interventions to prevent residents from entering non-resident areas. · Care plan for identified residents at risk were updated based on facility audit on July 21, 2025.	F 0689		

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F 0689 SS=J	Continued from page 17 · Resident R1 ' s care plan was updated upon return from hospitalization on July 23, 2025. 5. Ensure doors are functioning properly and staff are in-serviced on areas in the building where residents are restricted related to resident safety. · Ongoing security department monitoring and audit of identified doors to ensure that the doors are secured and functioning properly (Process effective as of July 26, 2025). 6. Provide staff training on ensuring residents don ' t enter areas of the building where residents are restricted from being related to resident safety. · Inglis House staff training on ensuring residents don ' t enter areas of the building where residents are restricted from related to resident safety started as of July 26, 2025, and is ongoing. · Facility has completed approximately 50	F 0689		

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F 0689 SS=J	Continued from page 18 percent of the training and is expected to complete 100 percent compliance by August 6, 2025. On August 1, 2025, the implementation of the action plan was verified. Interviewed 24 staff from various units, and departments. Staff was able to verbalize what they would in ensuring that residents don ' t enter areas of the building where residents are restricted from related to resident safety. Observed the setup of keypad lock to Morris Building to non-residential area in the presence of Employee E3. Reviewed the documents showing staff education completed as mentioned in the Action Plan. Reviewed the revised care plan for Resident R1. Review of residents' care plans confirmed that resident's care plans were updated to include that a resident was not to be left unattended. Following the verification of the immediate action plan the Immediate Jeopardy was lifted on August 1, 2025, at 2:53 p.m.	F 0689		

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F 0689 SS=J	Continued from page 19 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(a) Management 28 Pa Code 201.18(b)(1) Management 28 Pa Code 201.18(b)(3) Management 28 Pa Code 211.10(a) Resident care policies 28 Pa Code 211.10(d) Resident care policies 28 Pa Code 211.12(d)(3) Nursing services 28 Pa Code 211.12(d)(5) Nursing services	F 0689		
F 0835 SS=D		F 0835		

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F 0835 SS=D	Continued from page 20 483.70 Administration §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 0835	1) NHA and DON reviewed their Job descriptions and duties of the administrator and Director of nursing with the president and CEO of Inglis. 2) There are no like instances 3) Education to DON and Administrator was completed by the CEO of Inglis 4) Job descriptions will be reviewed annually.	Completion Date: **08/26/2025** Status: **APPROVED** Date: **08/28/2025**

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F 0835 SS=D	Continued from page 21 Based on review of clinical record, review of job's descriptions and interviews with staff, it was determined that the Nursing Home Administrator and Director of Nursing did not effectively manage the facility to ensure that adequate supervision was provided to on one of one resident reviewed (Resident R1) at risk for elopement. This failure resulted in Resident R1 wandering in the hallways of the facility on an electric wheelchair, and accessing the fire stairway entrance door, falling down a flight of stairs while strapped to the wheelchair. Resident R1 required transfer to the hospital and diagnosed with rib fractures, a fracture of the right clavicle, a subdural hematoma and closed dislocation of left finger and five stiches to the right top of the head. This deficiency was identified as Immediate Jeopardy Past Noncompliance. (Resident R1) Findings include: Review of the Nursing Home Administrator's	F 0835		

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F 0835 SS=D	Continued from page 22 (NHA) job description revealed that the Administrator is responsible for directing the day-to-day operations of the facility in accordance with current federal, state, and local standards and to ensure the highest degree of resident care and services are delivered and maintained. The Administrator serves as a member of the Inglis Senior Leadership Team, and in that capacity, provides input and support to the organization-wide strategic development, quality evaluation, communications, and culture building initiatives. Ensure facility is a safe, clean, comfortable, and appealing environment for residents, families, volunteers, visitors, and staff in accordance with company and regulatory guidelines. Continuously monitor to ensure that a safe and sanitary physical environment is maintained throughout the facility; that all equipment is maintained and functioning properly, and adequate, appropriate inventory levels of all supplies are available and used correctly. The Administrator is accountable for high-level oversight of Clinical Services for the Inglis House	F 0835		

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F 0835 SS=D	Continued from page 23 facility to support and maintain an ongoing quality assurance program based on clinical indicators, and to enable residents to reach optimal health and maximal function to achieve their goals and live full lives. Review of the Director of Nursing's job description revealed that the primary purpose of the Director of Nursing position is to utilize nursing knowledge and assessment skills in the development and implementation of individualized nursing care plans to ensure that customer needs and all applicable regulations are met. The Director of Nursing will also assist in the orientation and supervision of staff, attend to the daily operations of the Neighborhood and assume a leadership role. It is essential that all duties are performed with the highest level of integrity, while supporting Inglis Values and Standards of Excellence, ensuring the achievement of competencies and compliance with regulatory agencies. Job responsibilities included: Ensure resident safety by ensuring complete and accurate documentation of incidents and initiate investigations	F 0835		

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F 0835 SS=D	Continued from page 24 and interventions as indicated and maintains the confidentiality of all resident care information. Partners with the Neighborhood leaders to create a culture of learning, integrity, service and teamwork and supports safety and maintains clean facilities for residents and staff. Review of Resident R1's admission documentation revealed the resident was admitted to the facility on June 7, 2023, with diagnoses including Bipolar Disorder (mental health condition characterized by extreme shifts in mood, energy, and activity levels, cycling between periods of high and low and can significantly impacting a person's ability to function in daily life), and Dementia (group of symptoms affecting memory, thinking and social abilities.) Review of Resident R1's Quarterly MDS (Minimum Data Set - mandatory periodic resident assessment tool), dated May 14, 2025, revealed the resident was admitted to the facility on June 7, 2023, and with a diagnosis of Multiple sclerosis (chronic, often disabling disease that attacks the central nervous	F 0835		

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F 0835 SS=D	Continued from page 25 system-brain and spinal cord. It's an autoimmune disease, meaning the body's immune system mistakenly attacks its own tissues). Continued review revealed the resident had a BIMS (Brief Interview for Mental Status) score of five, which indicated the resident was severely cognitively impairment. Further review of the MDS revealed that the resident required Extensive Assistance for transfer. Review of Resident R1's care plan, initiated June 8, 2023, revealed that Resident R1 was an elopement risk related to disorientation to place, and due to impaired safety awareness; with interventions of Wander Alert, (safety device placed on resident which alarms/lock doors to the outside of the building), check for placement as per orders, air tag (tracking device designed to act as a key finder, which helps people find personal objects), monitoring when out of bed; and education to staff on ensuring resident does not enter restricted area (Morris Building, staff rooms, medical supply rooms, maintenance rooms, mechanical rooms,	F 0835		

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F 0835 SS=D	Continued from page 26 kitchen/food services areas, corporate offices). Revision date as July 3, 2025. Review of Risk Elopement Evaluations dated January 15, 2025, and May 11, 2025, for Resident R1 revealed Resident R1 was at risk of elopement. Review of clinical notes for Resident R1 revealed a nursing note, dated July 18, 2025, at 3:19 p.m., indicated "Resident out of bed to wheelchair at this time." Review of clinicalnotes for Resident R1 revealed a nursing note, dated July 19, 2025, at 12:13 a.m., indicated " at 10:22pm, NHA (Nursing Home Administrator) and DON (Director of Nursing) called and spoke to resident's wife RP (Responsible Party) about resident missing after dinner, and facility staff search each room and facility ground. Wife stated that she came in visit him today in the afternoon, left him in the room at 3:30 pm." Review of documentation submitted to the State	F 0835		

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F 0835 SS=D	Continued from page 27 Survey Agency on July 19, 2025, revealed that on July 18, 2025, " [Resident R1] was admitted to Inglis House on June 7, 2023 with a BIMS of 7, alert to name only. Resident is able to communicate needs. [Resident R1] non ambulatory, is able to use (his/hers) upper extremities, utilizes (his/her) power wheelchair for mobility, and is independent with locomotion. (He/She) was found in stairwell, ... around 11pm." " [Resident R1] finished a visit with (his/her spouse) around 3:30, (spouse) left (him/her) in (his/her) room to watch TV. (He/She) finished dinner around 5:45pm, video indicated that (he/she) was seen going down the hallway of 3 North towards the therapy side of the building. (He/She) continued through the double doors, to the next set of doors leading to the stairwell. " Stat 555 was called to the Morris Klein side of the building, resident was observed on the floor with (his/her) head in an upward position, and (his/her) wheelchair positioned behind (him/her). Resident was alert, seatbelt fastened, and from the knee up (he/she) was positioned on the landing of the staircase. Several male staff members including the RN	F 0835		

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F 0835 SS=D	Continued from page 28 supervisor, lifted (him/her) and chair in the upright position. Resident was sent out to Hospital for further evaluation." (Spouse) was made aware. Physician and hospice were notified ... [Resident R1] returned on Monday July 21st with a diagnosis of fall: Pneumothorax on the right, rib fractures 2-3-4, fracture of the right clavicle and subdural hematoma. Resident is negative for shortness of breath, chest pain, nausea and vomiting and Per family and (spouse) no medical or surgical interventions required. Resident is at baseline for mental status and resumed Hospice upon re-admission. (He/She) was re-admitting to a new room on the first floor across from the nursing station, and when out of bed (he/she) will be using a manual wheelchair. " During an interview on July 30, 2025, at 1:16 p.m., Employee E3, a Registered Nurse, who was the Nurse Supervisor for 1st, 2nd, and 3rd Floor North Side, at the time of the incident happened confirmed that on July 18, 2025, Resident R1 was in the dining room between 5:30 p.m.- 5:45 p.m. After dinner,	F 0835		

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F 0835 SS=D	Continued from page 29 before 8:00 p.m., Resident R1 was seen over 3 South, at the end of the hall and was instructed to return to (his/her) unit 3 North. At 8:00 p.m. Nurse Supervisor, Employee E3 was on the unit and staff informed Employee E3 that Resident R1 was nowhere to be found. Resident R1 is known to wander to different rooms, and the staff started to look on 3 North in all the rooms for Resident R1. Staff were not able to find Resident R1 on the 3rd North. Employee E3, called Security to overhead page for Resident R1 to return to (his/her) room. At 9:00 p.m. Employee E3 called the other supervisor to notify her that the staff could not find Resident R1, and to have her units look in all their rooms, elevators, shower rooms for the resident. At 9:45 p.m. Registered nurse, Employee E3 called the Nursing Home Administrator (NHA) and Director of Nursing (DON) to notify them Resident R1 was nowhere to be found in the facility. Resident R1 had a Roam alert and Security stated that it did not go off or show that he/she had exited externally from the building. The search for Resident R1	F 0835		

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F 0835 SS=D	Continued from page 30 continued to the internal portion of the courtyard and other areas of the building. At 10:28 p.m. the DON arrived, and staff had completed the check of all common areas, parking lot, courtyard, elevators, stairwells, and accessible areas of the business office that would be accessible for Resident R1. At 10:30 p.m. staff went to the business office side to check areas that Resident R1 would not normally be accessible to. A code was entered to go into the internal business office area on the third floor. Staff looked in the area and continued to the back stairwell of that area. At 10:45 p.m. Resident R1 was found by the , Environmental Service Director, Employee E14, on the landing at the bottom of the first set of steps. On July 30, 2025, at 11:41 a.m., interviewed the Director of Engineering Services, Employee E4, along with Assistant Nursing Home Administrator (ANHA), Employee E1, and Director of Nursing (DON) , Employee E2, showed the route the resident took on July 18, 2025 starting from the Third Floor Therapy Area hallway leading to Morris	F 0835		

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F 0835 SS=D	Continued from page 31 Hall Vestibule; at the beginning of Morris Hall office there is a door; which was left open accidently; there was no wanderguard detector (alarm mechanism which locks/alarms) on the door, as it was not part of resident area. ANHA, Employee E1, and DON, Employee E2 reasoned that Resident R1 moved forward in his/her wheelchair, pushed open the door at the fire stairway entrance door; and fell with his/her wheelchair below approximately eight small steps On August 1, 2025, at 11:24 a.m., interviewed Employee E14, Environmental Service Director, who found Resident R1, on July 18, 2025, at 10:45 p.m. Employee E14 stated that he found Resident R1 on the floor with (his/her) head in an upward position, and resident's wheelchair positioned behind him/her. Resident was alert, seatbelt fastened, and from the knee up resident was positioned on the landing of the staircase. Reviewed of Resident R1's hospital records revealed the resident was " Admitted on July 19,	F 0835		

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	395134	A. BLDG: 00 B. WING:	08/01/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
INGLIS HOUSE STATE LICENSE NUMBER: **090202**	**2600 BELMONT AVENUE** **PHILADELPHIA, PA 19131**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0835 SS=D	Continued from page 32 2025, from Nursing Home for fall on July 18, 2025, down flight of stairs who at baseline uses wheelchair due to right sided paralysis. Multiple injuries, including PTX (pneumothorax, a condition where air leaks into the space between the lung and chest wall, causing the lung to potentially collapse) with rib fractures 2-4, SDH (Subdural Hematoma- a condition where blood collects between the dura mater and arachnoid layers of the brain's protective coverings), right clavicular (the collarbone) fracture, left fourth digit (finger) dislocation, scalp hematoma (a collection of blood under the skin of the scalp, often appearing as a bump on the head), and multiple abrasions (a superficial skin injury caused by rubbing or scraping against a surface)...Admitted to trauma floor." Review of facility nursing progress note dated July 22, 2025, indicated the resident was readmitted to the facility at 12:30 p.m. Resident was awake and responsive, verbalizing needs without problems. The admitting diagnoses included "Trauma, closed dislocation of left finger, multiple rib fractures,	F 0835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0835 SS=D	Continued from page 33 Fracture of right clavicle, subdural hematoma ... 5 stitches to (right) top of head, bruise to (R) shoulder, red bruise to (left) side scalp, bruise to (R) side face, swelling to (R) hand, scab to (R) and (L) shin, chest tube puncture site to (R) side, abrasion to (L) shoulder, intact blister to (L) upper arm, scab to (R) outer ankle, splint to (R) finger, dressing intact." Based on the deficiencies identified in this report, the Nursing Home Administrator and Director of Nursing failed to fulfill essential duties and responsibilities of their position to ensure that the Federal and State guidelines and Regulations were followed, contributing to the Immediate Jeopardy situation. Refer to F689 28 Pa. Code: 201.18(b)(1) Management 28 Pa. Code: 201.18(b)(3) Management	F 0835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0835 SS=D	Continued from page 34	F 0835		

Certified End Page

INGLIS HOUSE

STATE LICENSE NUMBER: 090202

SURVEY EXIT DATE: 08/01/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY