

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395449	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/18/2024
NAME OF PROVIDER OR SUPPLIER: CHAPEL MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE: 1104 WELSH ROAD PHILADELPHIA, PA 19115		
STATE LICENSE NUMBER: 031602				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	F 0000		
F 0641	Based on a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance survey and an Abbreviated survey in response to two complaints completed on December 18, 2024, it was determined that Chapel Manor was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations as they relate to the Health portion of the survey	F 0641		
SS=D				

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 0641 SS=D	Continued from page 1 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	Resident R96 Quarterly MDS has been revised to remove use of physical restraints Resident R187 Quarterly MDS has been revised to reflect discharge to home. MDS Coordinator / Designee to conduct an initial audit of residents in past 30 days with Quarterly MDSs for accuracy of physical restraints and discharge disposition. NPE / DON / Designee to re-educate MDS Coordinators regarding accuracy of Quarterly MDS submissions. MDS Coordinator / Designee to complete weekly audits X 4 then monthly X 2 for residents with Quarterly MDSs to ensure accuracy of submissions for physical restraints and discharge disposition. MDS Coordinator will report the findings of the audits to the QAPI Committee X 3 months.	Completion Date: 02/10/2025 Status: APPROVED Date: 01/06/2025

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F 0641 SS=D	Continued from page 2 Based on observations, clinical record reviews and interviews with staff, it was determined that the facility failed to accurately complete MDS assessments for two of 39 residents reviewed (Residents R187 and R96). Findings include: Review of Resident R96's Quarterly MDS (Minimum Data Set - a mandatory periodic resident assessment tool) dated October 22, 2024, revealed that the resident was admitted to the facility on July 17, 2024, with diagnoses including cerebrovascular disease (damage to the brain from interruption of its blood supply) and hemiplegia (paralysis). Continued review revealed that Resident R96 used physical restraints daily (physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body).	F 0641		

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F 0641 SS=D	<p>Continued from page 3</p> <p>Review of physician orders and care plans for Resident R96 revealed no indication that the resident used or required physical restraints.</p> <p>Observation on December 15, 2024, at 11:00 a.m. revealed that no restraints were observed for Resident R96.</p> <p>Interview on December 17, 2024, at 10:11 a.m. Employee E10, licensed nurse, stated that the MDS assessment for Resident R96 was coded in error.</p> <p>Review of Resident R187's Discharge MDS, dated November 2, 2024, revealed that the resident was discharged to a short-term general hospital on November 2, 2024.</p> <p>Review of Resident R187's discharge plan, dated November 1, 2024, revealed that the resident would be discharging home with family.</p> <p>Review of progress notes for Resident R187 revealed a social service note, dated October 21,</p>	F 0641		

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F 0641 SS=D	<p>Continued from page 4</p> <p>2024, at 10:50 a.m. which indicated that discharge planning was reviewed, the resident expressed that she wanted to go home and that she needed transportation.</p> <p>Continued review of progress notes for Resident R187 revealed another social service note, dated October 23, 2024, at 4:38 p.m. which indicated that transportation was set up for the resident; stretcher transport services was arranged through the resident's insurance company.</p> <p>Further review of progress notes for Resident R187 revealed a general note, dated November 2, 2024, at 7:14 p.m. which indicated that the resident was discharged via stretcher transport.</p> <p>Interview on December 18, 2024, at 11:30 a.m. Employee E10, licensed nurse, stated that the discharge MDS assessment for Resident R187 was coded in error.</p> <p>28 Pa Code 211.5(f)(xi) Medical records</p>	F 0641		

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F 0641 SS=D	Continued from page 5	F 0641		
F 0657 SS=D	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	Resident R124 Care plan has been updated to reflect the goal and interventions with the ordered volume of water flush. DON / Designee to conduct an initial audit of current residents with physician orders for water flushes via tube to ensure care plan reflects volume of water flush. NPE / DON / Designee to re-educate professional nurses regarding updating care plan to reflect volume of water flush. DON / Designee to complete weekly audits X 4 then monthly X 2 for residents with orders for water flushes via tube to ensure care plan reflects volume of water flush. DON /Designee will report the findings of the audits to the QAPI Committee X 3 months.	Completion Date: 02/10/2025 Status: APPROVED Date: 01/06/2025

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F 0657 SS=D	Continued from page 6	F 0657			

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F 0657 SS=D	Continued from page 7 Based on observations, clinical record review, review of facility documents and staff interviews, it was determined that the facility failed to revise the care plan for Feeding-Related Care, for one of 36 residents reviewed (Resident R124). Findings include: Review of Resident R124's clinical record revealed that the Resident was admitted in the facility on April 07, 2021. R124's diagnoses included Dementia (Dementia is a set of symptoms that can be caused by a number of diseases which over time destroy nerve cells and damage the brain, typically leading to deterioration in cognitive function, the ability to process thought, beyond what might be expected from the usual consequences of biological aging), Severe Protein-Calorie Malnutrition (a condition that occurs when a person doesn't get enough protein, calories, and other nutrients from their food), Adult Failure to Thrive (a condition in older adults characterized by unexplained weight loss, poor nutrition, decreased appetite, inactivity, and	F 0657		

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F 0657 SS=D	Continued from page 8 often accompanied by declining physical and cognitive function), and Muscle Wasting and Atrophy (referring to the loss of muscle mass and strength, typically caused by a lack of physical activity, injury, malnutrition, or neurological conditions, resulting in a decrease in muscle size and function; essentially, the muscles are "wasting away" due to disuse or disease). Review of physician order for R124, dated November 19, 2024, indicated an order; "every shift automatic water flush: 55 ml/hr via PEG tube for 12 hours while enteral feed runs (total water over 24 hr = 660ml) and flush with 50 ml after each feeding". On December 17, 2024, at 9:37 a.m., review of the care plan of R124, revealed that it was not updated, or revised, to reflect the goal and interventions with the ordered volume of water flush. At the time of the findings, interview with the charge nurse, a Licensed Nurse, employee E19, confirmed the same.	F 0657		

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F 0657 SS=D	Continued from page 9 28 Pa Code 211.11(d) Resident Care Plan	F 0657		
F 0692 SS=D	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 0692	Resident R181 weekly weights obtained and recorded. Dietician to conduct initial audit on residents recommended for weekly weights in the past 30 days to ensure weekly weights obtained and recorded. NPE / DON / Designee to re-educate professional nurses on obtaining and recording weekly weights per dietician recommendations. Dietician to conduct weekly audits X 4 then monthly X 2 on residents recommended for weekly weights to ensure weights taken and recorded. Dietician will report the findings of the audits to the QAPI Committee X 3 months	Completion Date: 02/10/2025 Status: APPROVED Date: 01/06/2025

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F 0692 SS=D	Continued from page 10 Based on clinical record review, observations of residents and interviews with staff, it was determined that the facility failed to implement timely interventions for weight management of one of 36 residents reviewed (R181). Findings include: A review of the clinical record of Resident R181, revealed; admission in the facility on September 9, 2024. Diagnoses of R181 included Gastro-Esophageal Reflux Disease with Esophagitis,(Esophagitis is inflammation of the esophagus. The esophagus is the muscular tube that delivers food from your mouth to your stomach. Esophagitis can cause painful, difficult swallowing and chest pain), and Abnormal Weight Loss. A review of the resident R181's weight record revealed the following recorded weights: 12/2/2024 07:33 113.4 Lbs Mechanical Lift 11/18/2024 21:07 114.2 Lbs Mechanical Lift 11/1/2024 08:34 113.8 Lbs Mechanical Lift	F 0692		

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F 0692 SS=D	Continued from page 11 10/15/2024 13:26 115.2 Lbs Mechanical Lift 10/2/2024 09:56 116.4 Lbs Mechanical Lift 10/1/2024 10:50 115.2 Lbs Mechanical Lift 9/18/2024 13:33 126.4 Lbs Mechanical Lift 9/9/2024 21:03 135.1 Lbs Mechanical Lift Review of the weight record indicated -16.06 Lbs% weight difference during the last four months. Review of Nutrition Assessment Note by Registered Dietitian for R181, dated October 2, 2024, indicated; "Significant weight loss noted. Per hospital records, hospital weights are 111 lb and 148 lb. Unclear what resident's actual weight is. Resident has good po intakes. Recommend weekly weights to monitor. Will order house shake once daily to support po intake". Further review of clinical records revealed that no weekly weights were taken or recorded for R 181 as recommended by the Registered Dietitian. Interview with the Registered Dietitian, Employee	F 0692		

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F 0692 SS=D	Continued from page 12 E181, on December 17, 2024, at 1:24 p.m., confirmed the findings. Pa § 211.6. Dietary services.	F 0692			
F 0695 SS=D		F 0695			

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F 0695 SS=D	Continued from page 13 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	Resident R158 is receiving her PRN oxygen at 2L/minute per physician orders. DoN / Designee to conduct initial audit on residents receiving oxygen therapy to ensure accurate liter/minute per physician orders. NPE / DON / Designee to re-educate professional nurses to ensure physician orders followed for liters/minute for residents receiving oxygen therapy. DON / Designee to conduct weekly audits X 4 then monthly X 2 on 5 random residents receiving oxygen to ensure accurate liters/minute per physician orders. DON /Designee will report the findings of the audits to the QAPI Committee X 3 months.	Completion Date: 02/10/2025 Status: APPROVED Date: 01/06/2025

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F 0695 SS=D	Continued from page 14 Based on observation, clinical record review, review of facility policy and staff interview, it was determined that the facility failed to provide appropriate respiratory care and services for one of 36 residents reviewed (R158). Findings include: Review of Resident R158's clinical record revealed; the resident was initially admitted to the facility on October 23, 2023, and readmitted on March 20, 2024; diagnosed with Acute and Chronic Respiratory Failure with Hypoxia (a condition where the lungs are unable to adequately exchange oxygen, leading to low blood oxygen levels {hypoxia}, which can occur suddenly {acute} or develop over time {chronic}, causing significant breathing difficulties and potential complications depending on the severity and duration of the issue; essentially, it means the body isn't getting enough oxygen due to impaired lung function, either rapidly or gradually); Chronic Obstructive Pulmonary Disease (COPD- a common lung disease causing restricted airflow and	F 0695		

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F 0695 SS=D	Continued from page 15 breathing problems, in people with COPD, the lungs can get damaged or clogged with phlegm); and Atelectasis (a condition where part or all of a lung collapses, leading to a reduction in oxygen exchange). Review of clinical record indicated that R158 was ordered, dated July 31, 2024, with Oxygen at 2 Liters/Min, via Nasal Cannula, as needed, On December 15, 2024, at 11:25 a.m., and on December 17, 2024, at 9:44 a.m., observed that R158 was administered with Oxygen at 3 Liters/Min, via Nasal Canula., and not 2 Liters/Min, as ordered by the physician; and the same was confirmed with a Licensed Nurse, E19, at the time of the finding. 28 Pa. Code 211.12(d)(5) Nursing services	F 0695		

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F 0711 SS=D	483.30(b)(1)-(3) Physician Visits - Review Care/Notes/Order §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by:	F 0711	Resident R98 physician notes have been corrected to reflect no gastrostomy tube. NPE / DON / Designee to re-educate facility physicians and Advanced Practice Providers regarding accuracy of documentation and diagnosis in physician/provider notes. Medical Records to complete weekly audits X 4 then monthly X 2 on 5 random residents physician notes and diagnoses to ensure accuracy of gastrostomy tube documentation. Medical Records will report the findings of the audits to the QAPI Committee X 3 months.	Completion Date: 02/10/2025 Status: APPROVED Date: 01/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395449	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/18/2024	
NAME OF PROVIDER OR SUPPLIER: CHAPEL MANOR STATE LICENSE NUMBER: 031602		STREET ADDRESS, CITY, STATE, ZIP CODE: 1104 WELSH ROAD PHILADELPHIA, PA 19115		
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F 0711 SS=D	Continued from page 17 Based on observation, clinical record review, and interview with staff, it was determined that the facility did not ensure the physician notes were accurately completed related to resident assessment and gastrostomy status for one of 39 residents reviewed (Resident R98). Findings include: Review of clinical documentation for resident R98 revealed that she was admitted to the facility on August 16, 2019, with diagnoses including, but not limited to, Alzheimer's disease, dysphagia, and gastric ulcer. Review of physician's notes revealed that on June 29, 2024, July 28, 2024, August 25, 2024, September 22, 2024, October 26, 2024, and November 24, 2024, the attending physician, employee E15, wrote "monitor for chronic factors of gastrostomy (a surgical opening made through the abdominal wall and into the stomach, allowing for nutrition and medication to be administered through a tube; receiving nutrition in this was is called enteral feeding) feeding", and noted a diagnosis of	F 0711		

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F 0711 SS=D	Continued from page 18 gastrostomy status. Review of the resident's current and discontinued physician orders revealed no orders for enteral feeds or for care of a gastrostomy site. Observation of resident R98 on December 15, 2024 at 12:45 pm revealed the resident to be lying in bed, positioned on her left side, facing the door. There was no enteral feed equipment in the resident's room, and no gastrostomy present. Interview with the resident's care nurse, licensed nurse employee E14 on December 17, 2024, at 12:39 p.m. revealed that the resident "never had a feeding tube. She eats by mouth. She's on a pureed diet". In an interview with employee E15, physician, on December 17, 2024, at 2:35 p.m. he revealed that he had previously cared for a resident with the same last name as resident R98, and that the other resident had a gastrostomy. He stated that documenting it in the resident's record was an error	F 0711		

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F 0711 SS=D	Continued from page 19 and that resident R98 did not currently or previously have a gastrostomy. 28 Pa. Code 211.5(f) Clinical records	F 0711		
F 0730 SS=E		F 0730		

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F 0730 SS=E	Continued from page 20 483.35(d)(7) Nurse Aide Peform Review-12 hr/yr In-Service §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:	F 0730	Employees E20, E21 and E22 nurse aides have received their yearly performance evaluations. HR / DON / Designee to complete initial audit of nursing aides to ensure a yearly performance evaluation is completed. HR / Designee to re-educate nursing administration to ensure nurse aides receive a yearly performance evaluation. HR / Designee to complete monthly audits X 3 to ensure ongoing nurse aide yearly performance evaluations are completed. HR / Designee will report the findings of the audits to the QAPI Committee X 3 months.	Completion Date: 02/10/2025 Status: APPROVED Date: 01/06/2025

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F 0730 SS=E	Continued from page 21 Based on review of facility provided documentation and interview with staff, it was determined that the facility did not provide requested evidence of yearly performance evaluations for three out of five nurse aides reviewed (Employee E20, E21, and E22) Findings include: On Wednesday, December 18th, 2024 at 9:58 AM, an email was sent to facility's director of nursing, employee E1 requesting evidence of yearly performance reviews for nurse aides. Another verbal request for yearly performance evaluations was made to E1 on Wednesday, December 18th, 2024 at 1:20 PM. Facility was unable to provide evidence for yearly performance evaluations for nurse aides - E20, E21, E22; findings confirmed with facility's administrator and director of nursing. 28 Pa Code 211.12(d)(1) Nursing services	F 0730		

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F 0730 SS=E	Continued from page 22 28 Pa Code 211.12(d)(5) Nursing services	F 0730		
F 0732 SS=E	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 0732	Daily Nurse staffing data is posted in the lobby, 1st and 2nd floor. NPE / Designee to re-educate facility scheduler and nursing administration regarding posting of the daily nurse staffing data in lobby, 1st and 2nd floors. Scheduler / Designee will complete weekly audits X 4 then monthly X 2 on 3 random days per week to ensure daily nurse staffing data is posted in the lobby, 1st and 2nd floors. Scheduler / Designee will report the findings of the audits to the QAPI Committee X 3 months.	Completion Date: 02/10/2025 Status: APPROVED Date: 01/06/2025

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F 0732 SS=E	Continued from page 23 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:	F 0732		

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F 0732 SS=E	Continued from page 24 Based on observation, review of posted daily nurse staffing data, and staff interviews, it was determined that the facility did not ensure that nursing staffing information was posted on a prominent place readily accessible to residents on two out of two resident floors (First and Second floors) Findings include: Observations on Sunday, December 15, 2024 at 10:00 am revealed the facility did not post the nurse staffing data daily on the first and second floor that was readily accessible to residents in a clear and readable format. Further observations revealed that an assignment sheet was posted in facility's lobby area; which excluded facility name, total number and actual hours worked by registered nurses, licensed practical nurses and nurse aides and resident census. These findings were reviewed and confirmed with facility's administrator and supervisor, employee E5,	F 0732		

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F 0732 SS=E	Continued from page 25 on Wednesday, December 18th, 2024 at 2:00 PM. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 211.12(d)(1) Nursing services	F 0732		
F 0757 SS=D		F 0757		

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F 0757 SS=D	Continued from page 26 483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by:	F 0757	Resident R50 Abnormal Involuntary Movement Scale (AIMS) assessment has been completed per pharmacist recommendation. DON / Designee will complete an initial audit of residents receiving an antipsychotic to ensure an AIMS assessment is completed. NPE / DON / Designee to re-educate professional nurses to ensure an AIMS assessment is completed for residents receiving antipsychotics. DON / Designee to complete weekly audits X 4 then monthly X 2 for residents receiving an antipsychotic to ensure an AIMS assessment is completed. DON /Designee will report the findings of the audits to the QAPI Committee X 3 months.	Completion Date: 02/10/2025 Status: APPROVED Date: 01/06/2025

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F 0757 SS=D	Continued from page 27 Based on review of clinical records, and staff interviews, it was determined that the facility failed to ensure that residents were free from unnecessary medications for one out of five residents sampled. (R 150). Findings include: Resident R150 was admitted to the facility on June 16, 2022, Bipolar Disorder, (people with Bipolar Disorder often experience periods of extremely "up," elated, irritable, or energized behavior; known as manic episodes; and very "down," sad, indifferent, or hopeless periods; known as depressive episodes), Post-Traumatic Stress Disorder (a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event, series of events or set of circumstances; an individual may experience this as emotionally or physically harmful or life-threatening and may affect mental, physical, social, and/or spiritual well-being), Attention-Deficit Hyperactivity Disorder (ADHD) {Symptoms of ADHD include	F 0757		

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F 0757 SS=D	Continued from page 28 inattention [not being able to keep focus], hyperactivity (excess movement that is not fitting to the setting) and impulsivity [hasty acts that occur in the moment without thought], and Anxiety Disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). A review of the Physician order revealed that Resident R 150 had an order, dated August 23, 2024, for an antipsychotic medicine namely Olanzapine Oral Tablet 2.5 MG (Olanzapine), Give 2 tablet by mouth one time a day for Bipolar Disorder. (Olanzapine is an antipsychotic medication that can treat several mental health conditions like Schizophrenia and Bipolar Disorder). Review of pharmacist's evaluation for R 150, dated September 1, 2024, indicated that " antipsychotics have the capacity to cause Tardive Dyskinesia (Tardive Dyskinesia is a movement disorder that can develop as a side effect of taking certain medications, most commonly antipsychotic drugs	F 0757		

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F 0757 SS=D	Continued from page 29 used to treat mental health conditions and other movement disorders; symptoms include, involuntary, repetitive movements, typically involving the face, mouth, tongue, and limbs; grimacing, lip smacking, tongue thrusting, eye blinking, arm or leg movements, such as rocking, tapping, or jerking). The Pharmacist recommended movement test, such as AIMS (Abnormal Involuntary Movement Scale. It is a clinical rating scale used to assess the severity and frequency of involuntary movements, such as those caused by certain medications or neurological conditions), or DISCUSS (A "discuss test" related to antipsychotic assessment typically refers to a clinical interview or rating scale used to evaluate a patient's response to antipsychotic medication, focusing on discussing their current symptoms, side effects, and overall functioning while taking the medication; this could include standardized scales like the Abnormal Involuntary Movement Scale [AIMS] to assess for movement disorders or specific questionnaires regarding sexual function or other potential side effects depending on the patient's situation); be performed initially (within 30	F 0757		

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F 0757 SS=D	Continued from page 30 days), and then at least every six months while this resident continues on antipsychotic therapy. Further review of clinical records of R 150 did not reveal any occurrence of performing Abnormal Involuntary Movement Scale [AIMS] or DISCUSS as suggested by the Pharmacist. The facility failed to ensure that residents were free from unnecessary medications. During an interview conducted on December 18, 2024, at 11:10 a.m., the Nursing Supervisor, a Registered Nurse, Employee E5, confirmed these findings. 28 Pa Code 211.9(a)(1)(k) Pharmacy services	F 0757		
F 0812 SS=E		F 0812		

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F 0812 SS=E	Continued from page 31 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	Food is being served in accordance with professional standards for food service safety. Dietary manager will re-educate all dietary staff on proper dating, labeling, serving and storing foods. NHA/designee will conduct daily audit x 3 weeks and weekly audits x3 to ensure compliance Dietary manager will report the findings of the audit to the QAPI Committee X 3 months.	Completion Date: 02/10/2025 Status: APPROVED Date: 01/06/2025

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F 0812 SS=E	Continued from page 32 Based on observations, interviews with staff, and review of facility policy, it was determined that the facility did not ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety related to labeling and dating of food items and food wrapped or in covered containers Findings include: Review of facility policy titled "Food Storage: Cold Foods "Revised in September 2017. Revealed all food will be stored wrapped or in covered, labeled, and dated, and arranged in a manner to prevent cross contamination. A tour of the main kitchen was conducted with the supervisor cook, Employee E12, on December 15, 2024, at 9:33 a.m. revealed the following: Observation in the dry storage room revealed cans of food and fresh bread not having labeled and dated.	F 0812		

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NAME OF PROVIDER OR SUPPLIER: CHAPEL MANOR STATE LICENSE NUMBER: 031602		STREET ADDRESS, CITY, STATE, ZIP CODE: 1104 WELSH ROAD PHILADELPHIA, PA 19115		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 0812 SS=E	Continued from page 33 Observation in the walk-in refrigerator revealed food not having plastic wrap or covered and labeled with a date on pizza that will be serving for dinner. Observation a pie dessert plated without covers or plastic wrap and labeled and dated on the cookie trays. Further observation during lunch time on the second-floor dining room at 11:45 am dessert pie came out without cover or wrap. Continued observation in the kitchen on December 15, at 1: 08 p.m. revealed employees observed plated can pears into the bowel without covers and wrap. Interviewing food service director E13, on December 15, at 12:58 PM it was confirmed that those items needed to be wrapped or covered with labels and dated.	F 0812		

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F 0812 SS=E	Continued from page 34 28 Pa. Code 201.14 Responsibility of licensee 28 Pa. Code 201.18 (b) (3) Management	F 0812			
F 0842 SS=E		F 0842			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395449	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/18/2024	
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F 0842 SS=E	Continued from page 35 483.20(f)(5), 483.70(h)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 0842	Resident R98 gastrostomy diagnosis has been removed from the medical record. Medical Records will conduct an initial audit with a look back of 30 days to ensure accuracy of gastrostomy tube documentation Medical Records to complete weekly audits X 4 then monthly X 2 on 5 random residents diagnoses to ensure accuracy of gastrostomy tube documentation. Resident R40 pharmacy recommendation has been approved by the provider and appropriate diagnosis for Quetiapine has been added to the medical record. DON / Designee will complete an initial audit of pharmacy recommendations in the past 30 days to ensure recommendations for appropriate diagnosis for Quetiapine are updated and signed by the physician.	Completion Date: 02/10/2025 Status: APPROVED Date: 01/06/2025

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F 0842 SS=E	Continued from page 36 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 0842	DON / Designee to complete weekly audits X 4 then monthly X 2 to ensure recommendations for appropriate diagnosis for Quetiapine are updated and signed by the physician. NPE / DON / Designee to re-educate facility physicians, Advanced Practice Providers regarding accuracy of diagnosis in the medical record. DON /Designee will report the findings of the audits to the QAPI Committee X 3 months.	

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F 0842 SS=E	Continued from page 37 This REQUIREMENT is not met as evidenced by:	F 0842			

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F 0842 SS=E	Continued from page 38 Based on observation, clinical record review and interview with staff, it was determined that the facility did not ensure the residents record was complete and accurate related to diagnosis and pharmacy review for two of 39 residents reviewed (Resident R98 and R 40). Findings include: Review of clinical documentation for resident R98 revealed that she was admitted to the facility on August 16, 2019, and had diagnoses on record including, but not limited to, gastrostomy status (a surgical opening made through the abdominal wall and into the stomach, allowing for nutrition and medication to be administered through a tube), Alzheimer's disease, dysphagia, and gastric ulcer. Review of the resident's current and discontinued physician orders revealed no orders for enteral feeds or for care of a gastrostomy site. Observation of resident R98 on December 15, 2024, at 12:45 pm revealed the resident to be lying	F 0842		

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F 0842 SS=E	<p>Continued from page 39</p> <p>in bed, positioned on her left side, facing the door. There was no enteral feed equipment in the resident's room, and no gastrostomy present.</p> <p>Interview with the resident's care nurse, licensed nurse employee E14 on December 17, 2024, at 12:39 p.m. revealed that the resident "never had a feeding tube. She eats by mouth. She's on a pureed diet".</p> <p>In an interview with employee E15 on December 17, 2024, at 2:35 p.m. he revealed that he had previously cared for a resident with the same last name as resident R98, and that the other resident had a gastrostomy. He stated that documenting it in the resident's record was an error and that resident R98 did not currently or previously have a gastrostomy. No explanation was given about the consultant pharmacist recommendation to physician.</p> <p>Review of clinical documentation for resident R40 revealed that consultant pharmacist recommendation to physician for July 2024, stated this resident is</p>	F 0842		

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F 0842 SS=E	Continued from page 40 receiving the antipsychotic agent Quetiapine, but lacks an allowable diagnosis to support its use. This consultant pharmacist form was not signed and agreed or disagreed by the physician and no original copies was provided by the facility. 28 Pa. Code 211.5(f) Clinical records	F 0842		
F 0880 SS=D		F 0880		

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F 0880 SS=D	Continued from page 41 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	NPE / DON / Designee will re-educate nursing staff on appropriate PPE based on identified Enhanced Barrier Precautions. Infection Prevention Nurse / Designee to complete weekly audits X 4 then monthly X 2 on 5 random residents on Enhanced Barrier Precautions to ensure staff are utilizing appropriate PPE. DON /Designee will report the findings of the audits to the QAPI Committee X 3 months. Resident R49 remains on Enhanced Barrier Precautions with staff utilizing appropriate. PPE with provision of direct care. Infection Prevention Nurse / Designee to complete an initial audit of residents on Enhanced Barrier Precautions to ensure nursing staff utilizing appropriate PPE.	Completion Date: 02/10/2025 Status: APPROVED Date: 01/06/2025

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F 0880 SS=D	Continued from page 42 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880		

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F 0880 SS=D	Continued from page 43	F 0880		

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F 0880 SS=D	Continued from page 44 Based on observations, review of facility policies, review of facility documentation, clinical record review and interviews with staff, it was determined that the facility failed to maintain an effective infection control program related to Transmission Based Precautions for one of 36 residents reviewed (Resident R49). Findings include: Review of facility policy, "Infection Control Policies and Procedures, Enhanced Barrier Precautions" revised in December 2024, revealed that "Enhanced Barrier Precautions are infection control Intervention designed to reduce the transmission of novel or Multi-Drug Resistant Organisms. The policy stated to employ targeted personal protective equipment (PPE) use during high contact patient/resident activities. It also specified that" Multi-Drug Resistant Organisms (MDROs) are bacteria and other microorganisms that have developed resistance to one or more classes of antimicrobial drugs. The policy continued that	F 0880		

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F 0880 SS=D	<p>Continued from page 45</p> <p>ESBL-producing Enterobacterales are included in MDROs. (An ESBL infection is caused by bacteria that produce extended-spectrum beta-lactamase (ESBL), an enzyme that makes the bacteria resistant to many antibiotics; and Enterobacterales is an order of non-spore forming, rod-shaped bacteria).</p> <p>On December 15, 2024, review of facility list of residents with Enhanced Barrier Precautions showed that R49 was included in the list due to ESBL.</p> <p>On December 15, 2024, review of the physician order for R 49 revealed that R 49 had an order dated April 17, 2024, for Infection precautions due to enhanced barrier.</p> <p>Observation on December 15, 2024, at 11:55 a.m., revealed that Employee E16, a Nurse Aide, was providing cleaning care to R 49; but E16 did not wear the PPE, even though R16 was on Enhanced Barrier Precautions; and the same information was noted on the door of the resident</p>	F 0880		

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F 0880 SS=D	Continued from page 46 room. At the time of the finding, confirmed the same with Employee E16. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(d) Management	F 0880		
F 0919 SS=D	483.90(g)(1)(2) Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by:	F 0919	The malfunction part in the call bell system has been replaced and C wing call bell is functioning properly. Maintenance/designee will complete an initial audit on all call bell systems on each unit. Maintenance/designee will complete weekly audits x 4 then monthly X 2 to ensure the call bell system is functioning properly. Maintenance Director will report the findings of the audits to the QAPI Committee X 3 months.	Completion Date: 02/10/2025 Status: APPROVED Date: 01/06/2025

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F 0919 SS=D	Continued from page 47 Based on observations and interviews with staff, it was determined that the facility failed to ensure that call bell systems functioned properly for one of four nursing units observed (C-Wing nursing unit). Findings include: Observation on December 15, 2024, at 1:17 p.m. revealed that the call bell system was activated on the C-Wing nursing unit. The beeping of the alarm could be heard, however, no lights above any of the residents' rooms were illuminated. Observation of the call bell control panel at the C-Wing nurses station revealed that no lights were illuminated that would indicate which room activated their call bell. Employee E6, licensed nurse, stated that she could hear the call bell, however, she was unable to determine which room had activated their call bell. Employee E6, licensed nurse, walked up and down the halls looking for any indications of call bell activation, but was unable to see any. Employee E6, licensed nurse, then proceeded to go room by room	F 0919		

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F 0919 SS=D	Continued from page 48 on the C-wing nursing unit in attempts to locate which resident had activated their call bell. Employee E6, licensed nurse, determined that resident room 215A had activated their call bell. Employee E6, licensed nurse, confirmed that neither the light above room 215 nor the light at the nurses station control panel was illuminated while the call bell was activated. 28 Pa Code 205.67(k) Electric requirements for existing construction	F 0919		
F 0921 SS=E		F 0921		

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F 0921 SS=E	Continued from page 49 483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:	F 0921	Room 216 D wing wall trim has been repaired Room 214 D wing wall has been repaired. Room 215 C wing wall paper has been repaired Office chairs have been ordered for all of the wings C wing phones have been replaced Maintenance will complete an initial audit of all the rooms for needed repairs to the walls. Maintenance will audit all of the office chairs in the nursing units and order replacement for the damaged/broken chairs NPE will re-educate staff to add all repair needs to TELS system NHA/designee will conduct weekly audits x2 and monthly x1 to ensure compliance Maintenance Director will report the findings of the audits to the QAPI Committee X 3 months.	Completion Date: 02/10/2025 Status: APPROVED Date: 01/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395449	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/18/2024	
NAME OF PROVIDER OR SUPPLIER: CHAPEL MANOR STATE LICENSE NUMBER: 031602		STREET ADDRESS, CITY, STATE, ZIP CODE: 1104 WELSH ROAD PHILADELPHIA, PA 19115		
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F 0921 SS=E	<p>Continued from page 50</p> <p>Based on observations and interviews with staff, it was determined that the facility failed to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public, for four of four nursing units observed (A-Wing, B-Wing, C-Wing and D-Wing nursing units).</p> <p>Findings include:</p> <p>Observation on December 15, 2024, at 12:28 p.m. revealed that in room 216 on the D-Wing nursing unit, the wall trim behind the resident's bed was falling off from the wall.</p> <p>Continued observation on December 15, 2024, at 12:37 p.m. revealed that in room 214A on the D-Wing nursing unit, the wallpaper behind the resident's bed was peeling away from the wall.</p> <p>Continued observation on December 15, 2024, at 1:20 p.m. revealed that in room 215A on the C-Wing nursing unit, the wallpaper behind the resident's bed was peeling away from the wall.</p>	F 0921		

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F 0921 SS=E	Continued from page 51 Interview with Employee E6, licensed nurse, confirmed that the wallpaper was peeling away in the residents' rooms. Observation on December 15, 2024, at 1:43 p.m. of the C-Wing nurses station revealed that all of the chairs used by staff to complete tasks such as charting, phone calls and other general nursing duties were broken. None of the chairs would move up or down and the arm rests were deteriorated and worn down exposing hard plastic edges. Employees E6 and E7 stated that it was difficult to use the computers or work at the desk due to the broken chairs. Continued observation of the C-Wing nurses station revealed that the numbers on the desk phone had completely worn away; none of the numbers on the phone were visible. The second phone on the desk was broken, resulting in the phone tilting in a backward way, so that the phone would not stay on the receiver. Employees E6 and E7 stated that it was difficult to use the phones to make calls and that	F 0921		

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F 0921 SS=E	Continued from page 52 they were the only two phones located on the nursing unit. Observation on December 15, 2024, at 2:04 p.m. of the D-Wing nurses station revealed that all of the chairs used by staff to complete tasks such as charting, phone calls and other general nursing duties were broken. None of the chairs would move up or down and the arm rests were deteriorated and worn down exposing hard plastic edges. One of the chairs was stuck in a tilted downward position, making it difficult to sit on the chair. Employee E8, licensed nurse, confirmed that all of the chairs at the D-Wing nurses station were broken and uncomfortable for staff to use. Observation on December 15, 2024, at 12:43 p.m. of the A-Wing nurses station revealed that all of the chairs used by staff to complete tasks such as charting, phone calls and other general nursing duties were broken. The arm rests were deteriorated and worn down exposing hard plastic edges. The fabric on all of the chairs was threadbare, with holes	F 0921		

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F 0921 SS=E	Continued from page 53 becoming apparent on the corners. The seats were worn down, and uncomfortable to sit in. An interview with licensed nurse, employee E14, on December 18, 2024, at 12:39 p.m. confirmed that the chairs of the A-Wing nurses station were broken and uncomfortable, making it more difficult to complete charting and other necessary tasks. Observation on December 15, 2024, at 12:15 p.m. of the B-Wing nurses station revealed that all of the chairs used by staff to complete tasks such as charting, phone calls and other general nursing duties were broken. The arm rests were deteriorated and worn down exposing hard plastic edges, with one being wrapped in deteriorating black duct tape. The seat of one chair tipped forward when any pressure was placed on the back rest. Employee E17 stated that the chairs were in disrepair prior to their use at the nurses station, and that the state of disrepair made it "unpleasant" to sit in them when charting. 28 Pa Code 205.28(a) Nurses' station	F 0921		

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F 0921 SS=E	Continued from page 54 28 Pa Code 201.18(b)(3) Management	F 0921		
F 0924 SS=E		F 0924		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395449	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/18/2024
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F 0924 SS=E	Continued from page 55 483.90(i)(3) Corridors have Firmly Secured Handrails §483.90(i)(3) Equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by:	F 0924	Hand rails have been securely mounted on B, C and D wing Hand rails between room 215 and 213 have been replaced Hand rails between center stairwell have been replaced and securely mounted Maintenance will complete initial audit all nursing units and order replacement for the damaged/broken hand rails Maintenance will complete weekly audit x 2 and monthly x 1 to ensure handrails are secured and damage free NPE will re-educate staff to add all repair needs to TELS system NHA/designee will conduct weekly audits x2 and monthly x1 to ensure compliance Maintenance Director will report the findings of the audits to the QAPI Committee X 3 months.	Completion Date: 02/10/2025 Status: APPROVED Date: 01/06/2025

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F 0924 SS=E	Continued from page 56 Based on observations and interviews with staff, it was determined that the facility failed to ensure that corridors had firmly secured handrails on three of four nursing units observed (B-Wing, C-Wing and D-Wing nursing units). Findings include: Observations of the D-Wing nursing unit on December 15, 2024, at 12:42 p.m. revealed the following: The handrail between resident rooms 215 and 213 was missing, with tape covering the broken brackets for the handrail; The handrail between resident room 215 and the fire door was missing, with tape covering the broken brackets for the handrail; The handrail next to the center stairwell door was broken; The handrail between the center stairwell door and the soiled linen room was missing. Observations of the C-Wing nursing unit on	F 0924		

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F 0924 SS=E	Continued from page 57 December 15, 2024, at 12:48 p.m. revealed the following: The end cover on the handrail next to the clean linen room was missing, exposing the rough and sharp edge of the plastic and metal; The handrail between resident room 217 and the nurses station was missing. Interview on December 15, 2024, at 12:50 p.m. Employee E8, licensed nurse, confirmed that the handrails were broken and missing. Observation of the B-Wing nurses station on December 15, 2024, at 12:15 p.m. revealed that the hand rail on the wall beside the nurses station was missing, with a hole where one support post had been, and the other support posts left exposed. Closer inspection of the posts revealed them to have exposed sharp corners. Licensed nurse, employee E17, confirmed that the railing was missing and that the exposed posts were a potential hazard to residents and staff.	F 0924		

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F 0924 SS=E	Continued from page 58 28 Pa Code 205.9(a) Corridors	F 0924			

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P 5520	Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	There were no adverse effects to the residents in the center as a result of the CNA ratios for the night shift staffing during the months of May, September or December 2024. Chapel Manor will continue to use recruiters, our website, recruitment websites and social media to advertise our current open positions and interview immediately. Staffing meetings are held two times a day Monday-Friday to review staffing ratios from the previous day, the current day, and the upcoming week to ensure appropriate staffing levels. Staff has been educated on the attendance policy. The Scheduling Coordinator, Nursing Supervisors and Director of Nursing were re-educated on maintaining a CNAs per 10 residents on day shift, 11 residents on evening shift, and 15 residents on night shift. Administrator or designee to audit licensed nurse ratios for random all shifts weekly for 6 weeks. Findings will be reviewed in QAPI.	Completion Date: 02/10/2025 Status: APPROVED Date: 01/09/2025
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE:		(X6) DATE:

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P 5520	Continued from page 1 Based on review of nursing time schedules, and interview with staff, it was determined that facility did not ensure to provide a minimum of one nurse aide per 10 residents during day shift, minimum of one nurse aide per 11 residents during evening shift and a minimum of one nurse aide per 15 residents during night shift for 59 shifts out of 63 shifts reviewed. Findings include: Review of facility census data indicated that on 09/01/2024, the facility census was 191, which required 19.10 nurse aides during day shift. Review of nursing time schedules revealed 16.39 nurse aides provided care on the day shift on 09/01/2024. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data indicated that on 09/01/2024, the facility census was 191, which required 12.73 nurse aides during night shift.	P 5520		

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P 5520	Continued from page 2 Review of nursing time schedules revealed 10.61 nurse aides provided care on the night shift on 09/01/2024. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data indicated that on 09/02/2024, the facility census was 192, which required 19.20 nurse aides during day shift. Review of nursing time schedules revealed 16.87 nurse aides provided care on the day shift on 09/02/2024. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data indicated that on 09/03/2024 , the facility census was 194, which required 19.40 nurse aides during day shift. Review of nursing time schedules revealed 16.79 nurse aides provided care on the day shift on 09/03/2024. No additional excess higher-level staff were available to compensate this deficiency.	P 5520		

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P 5520	Continued from page 3 Review of facility census data indicated that on 09/04/2024, the facility census was 191, which required 17.36 nurse aides during evening shift. Review of nursing time schedules revealed 16.48 nurse aides provided care on the evening shift on 09/04/2024. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data indicated that on 09/04/2024, the facility census was 191, which required 12.73 nurse aides during night shift. Review of nursing time schedules revealed 10.83 nurse aides provided care on the night shift on 09/04/2024. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data indicated that on 09/05/2024 , the facility census was 193, which required 19.30 nurse aides during day shift.	P 5520		

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P 5520	Continued from page 4 Review of nursing time schedules revealed 16.88 nurse aides provided care on the day shift on 09/05/2024. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data indicated that on 09/05/2024, the facility census was 193, which required 17.55 nurse aides during evening shift. Review of nursing time schedules revealed 16.79 nurse aides provided care on the evening shift on 09/05/2024. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data indicated that on 09/05/2024, the facility census was 193, which required 12.87 nurse aides during night shift. Review of nursing time schedules revealed 10.81 nurse aides provided care on the night shift on 09/05/2024. No additional excess higher-level staff were available to compensate this deficiency.	P 5520		

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P 5520	Continued from page 5 Review of facility census data indicated that on 09/06/2024 , the facility census was 193, which required 19.30 nurse aides during day shift. Review of nursing time schedules revealed 16.17 nurse aides provided care on the day shift on 09/06/2024. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data indicated that on 09/06/2024, the facility census was 193, which required 17.55 nurse aides during evening shift. Review of nursing time schedules revealed 15.37 nurse aides provided care on the evening shift on 09/06/2024. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data indicated that on 09/07/2024 , the facility census was 193, which required 19.30 nurse aides during day shift. Review of nursing time schedules revealed 17.23	P 5520		

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P 5520	Continued from page 6 nurse aides provided care on the day shift on 09/07/2024. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data indicated that on 05/19/2024 , the facility census was 204, which required 10.20 nurse aides during night shift. Review of nursing time schedules revealed 9.09 nurse aides provided care on the evening shift on 05/19/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 05/20/2024 , the facility census was 201, which required 16.75 nurse aides during evening shift. Review of nursing time schedules revealed 16.60 nurse aides provided care on the evening shift on 05/20/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 05/20//2024 , the facility census was 201, which required 10.05 nurse aides during night shift.	P 5520		

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P 5520	Continued from page 7 Review of nursing time schedules revealed 8.11 nurse aides provided care on the night shift on 05/20/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 05/24/2024 , the facility census was 195, which required 16.25 nurse aides during day shift. Review of nursing time schedules revealed 14.71 nurse aides provided care on the day shift on 05/24/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 12/11/2024 , the facility census was 183, which required 16.64 nurse aides during evening shift. Review of nursing time schedules revealed 16.00 nurse aides provided care on the evening shift on 12/11/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 12/11/2024 , the facility census was 183, which	P 5520		

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NAME OF PROVIDER OR SUPPLIER: CHAPEL MANOR STATE LICENSE NUMBER: 031602		STREET ADDRESS, CITY, STATE, ZIP CODE: 1104 WELSH ROAD PHILADELPHIA, PA 19115		
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P 5520	Continued from page 8 required 12.20 nurse aides during night shift. Review of nursing time schedules revealed 10.00 nurse aides provided care on the night shift on 12/11/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 12/12/2024 , the facility census was 183, which required 16.64 nurse aides during evening shift. Review of nursing time schedules revealed 15.00 nurse aides provided care on the evening shift on 12/12/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 12/13/2024 , the facility census was 183, which required 12.20 nurse aides during night shift. Review of nursing time schedules revealed 8.00 nurse aides provided care on the night shift on 12/13/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on	P 5520		

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P 5520	Continued from page 9 12/14//2024 , the facility census was 182, which required 18.20 nurse aides during day shift. Review of nursing time schedules revealed 17.00 nurse aides provided care on the day shift on 12/24/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 12/14/2024 , the facility census was 182, which required 16.55 nurse aides during evening shift. Review of nursing time schedules revealed 16.00 nurse aides provided care on the evening shift on 12/14/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 12/14/2024 , the facility census was 182, which required 12.13 nurse aides during night shift. Review of nursing time schedules revealed 10.00 nurse aides provided care on the night shift on 12/14/2024. No additional excess higher-level staff were available to compensate this deficiency	P 5520		

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P 5520	Continued from page 10 Review of facility census data indicated that on 12/15/2024 , the facility census was 183, which required 18.30 nurse aides during day shift. Review of nursing time schedules revealed 14.00 nurse aides provided care on the day shift on 12/15/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 12/15/2024 , the facility census was 183, which required 16.64 nurse aides during evening shift. Review of nursing time schedules revealed 16.00 nurse aides provided care on the evening shift on 12/15/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 12/15/2024 , the facility census was 183, which required 12.20 nurse aides during night shift. Review of nursing time schedules revealed 9.00 nurse aides provided care on the night shift on 12/15/2024. No additional excess higher-level staff	P 5520		

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P 5520	<p>Continued from page 11</p> <p>were available to compensate this deficiency Review of facility census data indicated that on 12/16/2024 , the facility census was 183, which required 16.64 nurse aides during evening shift.</p> <p>Review of nursing time schedules revealed 16.00 nurse aides provided care on the evening shift on 12/16/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 12/16/2024 , the facility census was 183, which required 12.20 nurse aides during night shift.</p> <p>Review of nursing time schedules revealed 10.00 nurse aides provided care on the night shift on 12/16/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 12/17/2024 , the facility census was 183, which required 16.64 nurse aides during evening shift.</p> <p>Review of nursing time schedules revealed 16.00 nurse aides provided care on the evening shift on</p>	P 5520		

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P 5520	Continued from page 12 12/17/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 12/17/2024 , the facility census was 183, which required 12.20 nurse aides during night shift. Review of nursing time schedules revealed 10.00 nurse aides provided care on the night shift on 12/17/2024. No additional excess higher-level staff were available to compensate this deficiency	P 5520		
P 5530		P 5530		

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P 5530	Continued from page 13 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	There were no adverse effects to the residents in the center as a result of the Licensed Practical Nurse ratios for the night shift staffing during the months of May, September and December 2024. Chapel Manor will continue to use recruiters, our website, recruitment websites and social media to advertise our current open positions and interview immediately. Staffing meetings are held two times a day Monday-Friday to review staffing ratios from the previous day, the current day, and the upcoming week to ensure appropriate staffing levels. Staff has been educated on the attendance policy. The Scheduling Coordinator, Nursing Supervisors and Director of Nursing were re-educated on maintaining a licensed nurse ratio of one licensed nurse per 25 residents on day shift, 30 residents on evening shift, and 40 residents on night shift. Administrator or designee to audit	Completion Date: 02/10/2025 Status: APPROVED Date: 01/09/2025

Pennsylvania Department of Health

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P 5530	Continued from page 14	P 5530	licensed nurse ratios for random all shifts weekly for 6weeks. Findings will be reviewed in QAPI.		

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P 5530	<p>Continued from page 15</p> <p>Based on review of nursing schedules and staff interview, it was determined that the facility administrative staff did not ensure to provide a minimum of one LPN (Licensed Practical Nurse) per 25 residents during day shift, a minimum of one LPN per 30 residents during evening shift, and one LPN per 40 residents during night shift for 57 out of 63 shifts reviewed.</p> <p>Findings include:</p> <p>Review of facility census data indicated that on 09/03/2024, the facility census was 194, which required 7.76 LPN's during evening shift.</p> <p>Review of the nursing time schedules revealed 7.30 LPN's provided care on the evening shift on 09/03/2024. No additional excess higher-level staff were available to compensate this deficiency.</p> <p>Review of facility census data indicated that on 09/03/2024, the facility census was 194, which required 4.85 LPN's during night shift.</p>	P 5530		

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P 5530	Continued from page 16 Review of the nursing time schedules revealed 4.33 LPN's provided care on the night shift on 09/03/2024. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data indicated that on 09/04/2024, the facility census was 191, which required 7.64 LPN's during day shift. Review of the nursing time schedules revealed 7.00 LPN's provided care on the day shift on 09/04/2024. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data indicated that on 09/07/2024, the facility census was 193, which required 7.72 LPN's during day shift. Review of the nursing time schedules revealed 7.18 LPN's provided care on the day shift on 09/07/2024. No additional excess higher-level staff were available to compensate this deficiency.	P 5530		

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P 5530	Continued from page 17 Review of facility census data indicated that on 09/07/2024, the facility census was 193, which required 12.87 LPN's during night shift. Review of the nursing time schedules revealed 10.80 LPN's provided care on the night shift on 09/07/2024. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data indicated that on 05/19/2024, the facility census was 204, which required 6.80 LPN's during evening shift. Review of the nursing time schedules revealed 6.68 LPN's provided care on the evening shift on 05/19/2024. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data indicated that on 05/19/2024, the facility census was 204, which	P 5530		

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P 5530	Continued from page 18 required 10.20 LPN's during night shift. Review of the nursing time schedules revealed 9.09 LPN's provided care on the night shift on 05/19/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 05/20/2024, the facility census was 201, which required 8.04 LPN's during day shift. Review of the nursing time schedules revealed 6.76 LPN's provided care on the day shift on 05/20/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 05/23/2024, the facility census was 198, which required 7.92 LPN's during day shift. Review of the nursing time schedules revealed 7.26 LPN's provided care on the day shift on 05/23/2024. No additional excess higher-level staff	P 5530		

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P 5530	Continued from page 19 were available to compensate this deficiency Review of facility census data indicated that on 05/24/2024, the facility census was 195, which required 7.80 LPN's during day shift. Review of the nursing time schedules revealed 7.44 LPN's provided care on the day shift on 05/24/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 05/25/2024, the facility census was 195, which required 4.88 LPN's during evening shift. Review of the nursing time schedules revealed 4.58 LPN's provided care on the night shift on 05/25/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 12/24/2024, the facility census was 183, which required 7.32 LPN's during day shift. Review of the nursing time schedules revealed 6.00 LPN's provided care on the day shift on	P 5530		

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P 5530	Continued from page 20 12/11/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 12/11/2024, the facility census was 183, which required 6.10 LPN's during evening shift. Review of the nursing time schedules revealed 5.38 LPN's provided care on the evening shift on 12/11/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 12/13/2024, the facility census was 183, which required 7.32 LPN's during day shift. Review of the nursing time schedules revealed 6.81 LPN's provided care on the day shift on 12/13/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 12/13/2024, the facility census was 183, which required 4.58 LPN's during night shift. Review of the nursing time schedules revealed 3.00	P 5530		

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P 5530	Continued from page 21 LPN's provided care on the night shift on 12/13/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 12/14/2024, the facility census was 182, which required 7.28 LPN's during day shift. Review of the nursing time schedules revealed 5.69 LPN's provided care on the day shift on 12/14/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 12/15/2024, the facility census was 183, which required 7.32 LPN's during day shift. Review of the nursing time schedules revealed 5.69 LPN's provided care on the day shift on 12/15/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 12/16/2024, the facility census was 183, which required 7.32 LPN's during day shift.	P 5530		

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P 5530	Continued from page 22 Review of the nursing time schedules revealed 5.63 LPN's provided care on the day shift on 12/15/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 12/16/2024, the facility census was 183, which required 6.10 LPN's during evening shift. Review of the nursing time schedules revealed 2.31 LPN's provided care on the evening shift on 12/16/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 12/16/2024, the facility census was 183, which required 4.58 LPN's during night shift. Review of the nursing time schedules revealed 3.94 LPN's provided care on the night shift on 12/16/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 12/17/2024, the facility census was 183, which required 7.32 LPN's during day shift.	P 5530		

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P 5530	Continued from page 23 Review of the nursing time schedules revealed 6.00 LPN's provided care on the day shift on 12/17/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 12/17/2024, the facility census was 183, which required 6.10 LPN's during evening shift. Review of the nursing time schedules revealed 5.44 LPN's provided care on the evening shift on 12/16/2024. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data indicated that on 12/17/2024, the facility census was 183, which required 4.58 LPN's during night shift. Review of the nursing time schedules revealed 4.00 LPN's provided care on the night shift on 12/17/2024. No additional excess higher-level staff were available to compensate this deficiency	P 5530		

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P 5530	Continued from page 24	P 5530		
P 5540		P 5540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395449	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/18/2024
NAME OF PROVIDER OR SUPPLIER: CHAPEL MANOR STATE LICENSE NUMBER: 031602		STREET ADDRESS, CITY, STATE, ZIP CODE: 1104 WELSH ROAD PHILADELPHIA, PA 19115		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5540	Continued from page 25 Nursing services. (5) Effective July 1, 2023, a minimum of 1 RN per 250 residents during all shifts. This REGULATION is not met as evidenced by:	P 5540	There were no adverse effects to the residents in the center as a result of the Registered Nurse ratios for the night shift staffing during the months of May, September and December 2024. Chapel Manor will continue to use recruiters, our website, recruitment websites and social media to advertise our current open positions and interview immediately. Staffing meetings are held two times a day Monday-Friday to review staffing ratios from the previous day, the current day, and the upcoming week to ensure appropriate staffing levels. Staff has been educated on the attendance policy. The Scheduling Coordinator, Nursing Supervisors and Director of Nursing were re-educated on maintaining a licensed nurse ratio of one licensed nurse per 250 residents on each shift. Administrator or designee to audit licensed nurse ratios for random all	Completion Date: 02/10/2025 Status: APPROVED Date: 01/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395449	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 12/18/2024
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P 5540	Continued from page 26	P 5540	shifts weekly for 6 weeks. Findings will be reviewed in QAPI.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395449	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/18/2024	
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P 5540	<p>Continued from page 27</p> <p>Based on review of nursing schedules and staff interview , it was determined that the facility administrative staff did not ensure to provide a minimum of one registered nurse (RN) for four days of 21 days reviewed.</p> <p>Findings include:</p> <p>Review of facility census data indicated that on 09/02/2024, facility census was 192, which required 1 RN during day shift.</p> <p>Review of the nursing schedules revealed 0.79 RN provided care on day shift on 09/02/2024. No additional excess higher-level staff were available to compensate this deficiency.</p> <p>Review of facility census data indicated that on 05/23/2024, facility census was 198, which required 1 RN during evening shift.</p> <p>Review of the nursing schedules revealed 0.99 RN provided care on day shift on 05/23/2024. No</p>	P 5540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395449	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/18/2024
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P 5540	Continued from page 28 additional excess higher-level staff were available to compensate this deficiency. Review of facility census data indicated that on 05/23/2024, facility census was 198, which required 1 RN during night shift. Review of the nursing schedules revealed 0.96 RN provided care on night shift on 05/23/2024. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data indicated that on 05/24/2024, facility census was 195, which required 1 RN during night shift. Review of the nursing schedules revealed 0.95 RN provided care on night shift on 05/24/2024. No additional excess higher-level staff were available to compensate this deficiency.	P 5540		

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P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395449	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/18/2024
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P 5640	Continued from page 30 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	There were no adverse effects to the residents in the center as a result of less than 3.2 direct care for each resident were provided during the months of September and December 2024. Chapel Manor will continue to use recruiters, our website, recruitment websites and social media to advertise our current open positions and interview immediately. Staffing meetings are held two times a day Monday-Friday to review staffing ratios from the previous day, the current day, and the upcoming week to ensure appropriate staffing levels. Staff has been educated on the attendance policy. The Scheduling Coordinator, Nursing Supervisors and Director of Nursing were re-educated on maintaining a minimum of 3.2 direct resident care for each resident. Administrator or designee to complete random audits weekly for 6 weeks for licensed nurse ratios for all shifts to ensure 3.2 PPD is	Completion Date: 02/10/2025 Status: APPROVED Date: 01/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395449	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/18/2024
NAME OF PROVIDER OR SUPPLIER: CHAPEL MANOR STATE LICENSE NUMBER: 031602		STREET ADDRESS, CITY, STATE, ZIP CODE: 1104 WELSH ROAD PHILADELPHIA, PA 19115		
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P 5640	Continued from page 31	P 5640	maintained Findings will be reviewed in QAPI. Findings will be reviewed in QAPI.	

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P 5640	Continued from page 32 Based on review of nursing time schedules, and staff interviews, it was determined that the facility did not ensure to provide a minimum of 3.2 hours of direct nursing care per resident for weeks of September 2024 and December 2024 on 16 of 21 days reviewed. Findings include: Review of facility census data, and nursing time schedules revealed that on 09/01/2024, the facility census was 191, and 3.12 hours of direct nursing care per resident were provided. Review of facility census data, and nursing time schedules revealed that on 09/02/2024, the facility census was 191, and 3.06 hours of direct nursing care per resident were provided. Review of facility census data, and nursing time schedules revealed that on 09/03/2024, the facility census was 194, and 3.10 hours of direct nursing care per resident were provided.	P 5640		

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P 5640	Continued from page 33 Review of facility census data, and nursing time schedules revealed that on 09/04/2024, the facility census was 191, and 3.04 hours of direct nursing care per resident were provided. Review of facility census data, and nursing time schedules revealed that on 09/05/2024, the facility census was 193, and 3.01 hours of direct nursing care per resident were provided. Review of facility census data, and nursing time schedules revealed that on 09/06/2024, the facility census was 193, and 2.84 hours of direct nursing care per resident were provided. Review of facility census data, and nursing time schedules revealed that on 09/07/2024, the facility census was 193, and 2.86 hours of direct nursing care per resident were provided. Review of facility census data, and nursing time schedules revealed that on 12/11/2024, the facility	P 5640		

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P 5640	Continued from page 34 census was 183, and 3.02 hours of direct nursing care per resident were provided. Review of facility census data, and nursing time schedules revealed that on 12/12/2024, the facility census was 183, and 3.07 hours of direct nursing care per resident were provided. Review of facility census data, and nursing time schedules revealed that on 12/13/2024, the facility census was 183, and 3.11 hours of direct nursing care per resident were provided. Review of facility census data, and nursing time schedules revealed that on 12/14/2024, the facility census was 182, and 2.90 hours of direct nursing care per resident were provided. Review of facility census data, and nursing time schedules revealed that on 12/15/2024, the facility census was 183, and 2.73 hours of direct nursing care per resident were provided.	P 5640		

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P 5640	Continued from page 35 Review of facility census data, and nursing time schedules revealed that on 12/16/2024, the facility census was 183, and 2.61 hours of direct nursing care per resident were provided. Review of facility census data, and nursing time schedules revealed that on 12/17/2024, the facility census was 183, and 3.10 hours of direct nursing care per resident were provided.	P 5640		



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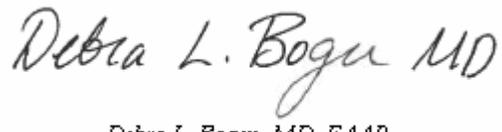
CHAPEL MANOR

STATE LICENSE NUMBER: 031602

SURVEY EXIT DATE: 12/18/2024

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, 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