

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395449</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/01/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>CHAPEL MANOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>1104 WELSH ROAD PHILADELPHIA, PA 19115</b>		
STATE LICENSE NUMBER: <b>031602</b>				
(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 0600	Based on an Abbreviated survey in response to one reportable incident completed on April 01, 2025, 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.	F 0600		
SS=G				

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 0600  SS=G	Continued from page 1  483.12(a)(1) Free from Abuse and Neglect  §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.  §483.12(a) The facility must-  §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;  This REQUIREMENT is not met as evidenced by:	F 0600	The facility cannot retroactively correct the cited deficient practice. An initial observation of care will be conducted of 5 residents receiving care on each shift to verify residents' beds are placed in a safe position after the completion of care.  The NPE or designee will re-inservice nursing staff on the Safe Resident Handling policy with the focus on placing residents' beds in a safe position after the completion of care.  The NPE or designee will re-inservice nursing staff on the Abuse policy.  The DON or designee will conduct random observations of 5 residents receiving care weekly x 4, then monthly x 2 to verify residents beds are placed in a safe position after the completion of care. Results of the audits will be presented at the QAPI meetings for review.  Date of compliance May 6, 2025	Completion Date: <b>05/06/2025</b> Status: <b>APPROVED</b> Date: <b>04/16/2025</b>

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F 0600  SS=G	Continued from page 2  Based on review of clinical record, facility policy, facility documentation, and staff interviews, it was determined the facility failed to ensure Resident R1 was free from neglect by failing to place Resident R1's bed in a safe position after the completion of care. This failure resulted in actual harm to Resident R1 who fell out of bed, sustained a subdural hematoma and an intertrochanteric fracture of left femur (thigh) for one of four residents reviewed for falls (Resident R1).  Findings include:  Review of facility policy titled "Falls Management," revised 2024, revealed patients will be assessed for risk of falling as part of the nursing assessment process. Interventions to reduce risk and minimize injury will be implemented as appropriate. Also, practice standards include implementing and documenting patient-centered interventions according to individual risk factors in the patient's care plan.	F 0600		

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F 0600  SS=G	Continued from page 3  Review of Resident R1's clinical record revealed the resident was admitted to the facility on April 15, 2021, with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD- prevents airflow to the lungs, causing breathing problems), Osteoporosis (condition that weakens bones and increases the risk of fractures), and Dementia (decline in cognitive function that interferes with daily life).  Review of Resident R1's quarterly Minimum Data Set (MDS- mandated assessment of a resident's abilities and care needs), dated February 4, 2025, revealed Resident R1 had a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. The resident was assessed with lower extremities impairment, dependent of staff for rolling from left to right, for moving from lying position to a sitting position and from bed to chair transfer.  Review of Resident R1's care plan, dated April 16, 2021, revealed Resident R1 was at risk for falls	F 0600		

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F 0600  SS=G	Continued from page 4  related to cognitive loss, lack of safety awareness, side effects of medications, vertigo (sensation of spinning or dizziness), COPD, pain in feet, and impaired balance. One of the interventions to limit falls included Resident R1's bed to be in lowest position.  Review of documentation submitted to the State Survey Agency on March 18, 2025, revealed on March 17, 2025, after Resident R1 received morning care, the resident was left lying on his/her right side in bed. The nurse aide turned to get the resident's wheelchair and the resident rolled out of bed and landed on the left side, hitting the left side of the head on the floor. The nurse aide was not able to stop the fall. The resident was assessed for any injuries and was noted with a hematoma on the left side of head.  Review of facility investigation, dated March 17, 2025, revealed Resident R1 received morning care on March 17, 2025, at approximately 11:20 a.m. Resident R1 was then lying flat in the middle of the	F 0600		

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F 0600  SS=G	Continued from page 5  bed after care was performed. Nurse Aide, Employee E1, then walked away from the bed to retrieve Resident R1's wheelchair near the door. Resident R1 then turned to his/her side, rolled out of bed, and landed on his/her left side. Resident R1 hit the left side of the head and was noted with a hematoma on the left side of resident's head. Resident R1 complained of left foot pain. X-ray was ordered and results confirmed positive fracture of acute left trochanteric (thigh) area. Resident R1 was transferred to the emergency department for further evaluation and treatment.  Review of Resident R1's physician notes dated March 17, 2025, (12:16 p.m.) revealed Resident R1 experienced a fall, resulting in a hematoma on the resident's left forehead and left sided pain, particularly in the lower extremity. "There is a high concern for a femur fracture given the immediate pain in [his/her] left lower extremity. The potential for neurological complications.. subdural hematoma exists... Immediate transfer to the emergency department is requited if any changes are observed,	F 0600		

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F 0600  SS=G	Continued from page 6  due to risk of ... subdural hematoma."  Review of Resident R1's nursing notes dated March 18, 2025, at 8:24 a.m. indicated "resident left face had bruised, ice was apply for comfort."  Review of nursing notes dated March 18, 2025, at 8:26 a.m. revealed the physician called and ordered for the resident to be transferred to the hospital for hematoma.  Continued review of Resident R1's nursing note dated March 19, 2025, at 1:40 a.m. revealed that a call was made to the hospital "nurse reported resident admitted with subdural hematoma and fracture of left femur."  Review of Resident R1's hospital discharge summary document, dated March 24, 2025, confirmed Resident R1 was diagnosed with a subdural hematoma and intertrochanteric fracture of left femur.	F 0600		

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F 0600  SS=G	<p>Continued from page 7</p> <p>Interview conducted on April 01, 2025, at 10:39 a.m. with Nurse Aide, Employee E1, revealed Employee E1 raised Resident R1's bed while providing care and the bed was at the height of Employee E1's waist. After care was performed, Employee E1 then walked away from Resident R1's bed to retrieve resident's wheelchair. Employee E1 confirmed Resident R1's bed was left in the high position when she walked away.</p> <p>Interview on April 01, 2025, at 11:53 a.m. with Director of Nursing, Employee E2, confirmed Resident R1's bed should be in the low position when away from the bed.</p> <p>The facility failed to ensure that Resident R1 was free from neglect by failing to place Resident R1's bed in a safe position after the completion of care. This failure resulted in actual harm to Resident R1 who fell out of bed and sustained a subdural hematoma and a intertrochanteric fracture of left femur.</p>	F 0600		

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F 0600  SS=G	Continued from page 8  28 Pa. Code 201.14(a) Responsibility of licensee.  28 Pa. Code 201.18(e)(1) Management.  28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0600			



# Certified End Page

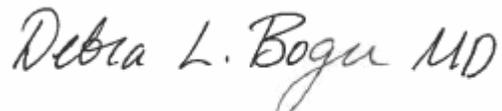
**CHAPEL MANOR**

**STATE LICENSE NUMBER: 031602**

**SURVEY EXIT DATE: 04/01/2025**

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

  
Jeanne Parisi  
Deputy Secretary for Quality Assurance

  
Debra L. Bogen, MD, 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