

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395485	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/31/2025
NAME OF PROVIDER OR SUPPLIER: GRADUATE POST ACUTE		STREET ADDRESS, CITY, STATE, ZIP CODE: 1526 LOMBARD STREET PHILADELPHIA, PA 19146		
STATE LICENSE NUMBER: 200402				
(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 0689 SS=J	<p>Based on an abbreviated survey in response to a reportable incident completed on January 31, 2025, it was determined that Graduate Post Acute 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.</p> <p>483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices</p> <p>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 0689	Past noncompliance: no plan of correction required.	<p>Completion Date: 02/12/2025 Status: APPROVED Date: 02/13/2025</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

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

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

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F 0689 SS=J	Continued from page 2 Based on review of facility policies and documentation, clinical record reviews and interviews with staff, it was determined that the facility failed to provide adequate supervision to one of one resident reviewed (Resident R1) who was at risk for elopement. This failure resulted in Resident R1 exiting the third floor via elevator and walking out the front entrance doors. Resident R1 was unable to be located for over 24 hours. This failure placed the resident at high risk for injury and was identified as an Immediate Jeopardy of past non-compliance. (Resident R1) Findings include: Review of facility policy, "Wander Management and Elopement Prevention" dated March 2022, revealed that "the facility will maintain the safety of residents who wander and/or at risk for elopement." Further review revealed that "staff will implement routine checks for placement and functionality" and that the "Wander management system devices will be	F 0689		

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F 0689 SS=J	Continued from page 3 checked for placement each shift" and "will be checked for functionality daily by nursing staff." Review of Resident R1's nursing notes revealed that the resident was admitted on January 20, 2025, with past medical history of stroke, Schizophrenia with prior psychosis (a collection of symptoms where a person has trouble distinguishing between what is real and what is not) and intermittent agitation, cognitive dysfunction. Further review of clinical records revealed a progress note by Nurse Practitioner, Employee E4, dated January 21, 2025, at 10:07 a.m. which indicated that Resident R1 was previously hospitalized and was "determined not to have decisional capacity due to underlying dementia. He was granted a legal guardian, who should be used for decision making." Review of facility documentation titled, Admission/Readmission Evaluation Packet, dated January 20, 2025, revealed that the resident had no	F 0689		

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F 0689 SS=J	Continued from page 4 history of elopement while at home; no history of verbally expressing the desire to go home or stay near the exit door. Further review of the admission evaluation revealed that the resident wanders aimlessly or non-goal-directed (i.e. confused, moves without purpose, may enter others' rooms and explore others' belongings). Continued review of the evaluation Question 15- "Is resident at risk for wander/elopement?" revealed that the answer was- no. During interview with Licensed Nurse, Employee E6, on January 30, 2025, at 10:40 a.m. Question 15 of the above Admission Evaluation was reviewed. Licensed nurse, Employee E6 indicated that the resident was at risk for elopement and had no answer as to why the resident was coded not at risk. Continued interview with Employee E6 confirmed that an elopement care plan was developed/initiated January 21, 2025. Review of Resident R1's care plan revealed a care plan date-initiated January 21, 2025, which	F 0689		

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F 0689 SS=J	Continued from page 5 indicated that the resident was at "actual / potential risk for elopement r/t (related to) adjustment reactions, cognitive impairment, New environment, non-acceptance of long-term placement." Review of nursing note for Resident R1 revealed a nurse's note, dated January 23, 2025, at 10:36 p.m. which indicated that when the Nurse Assistant entered Resident R1's room to deliver his dinner tray, she noted that Resident R1 was not present. The Nurse aide searched the unit for Resident R1 and immediately notified nursing administration; a search of all areas of the facility was performed. Further review revealed a nursing note dated, January 25, 2025, at 2:49 a.m. (over 48 hours since January 23, 2025, when the resident was noted missing) which indicated that the resident "arrived to the unit with the Director of Nursing." Upon arrival, Resident R1 was escorted to their room and assessed. Due to respiratory concerns, Resident R1 was sent to the Emergency Room for further evaluation. Resident R1 returned to the facility	F 0689		

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F 0689 SS=J	Continued from page 6 shortly after and was placed under one-to-one supervision. Review of nursing note dated January 25, 2025, at 7:35 a.m. indicated that the resident returned from hospital Emergency Room "1:1 protocol was instituted. Resident continues 1:1 care for elopement risk." Review of facility documentation reported to the State Survey Agency on January 23, 2025, at 6:30 a.m. revealed that Resident R1 was last seen by staff at 3:00 p.m. It was determined that Resident R1 took the elevator from the third-floor nursing unit and exiting through the doors of the main entrance of the facility. On January 25, 2025, at 12:21 a.m. the Director of Nursing, Employee E2 received a call from a nearby center stating that the resident came to their facility. Resident R1 returned to the nursing facility on January 25, 2025, at 2:49 p.m. Review of internet maps revealed that the center in which the resident was located was 2.2 miles,	F 0689		

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F 0689 SS=J	<p>Continued from page 7</p> <p>approximately a fifty-minute walk, from the nursing facility, in a busy urban area.</p> <p>Interview with the Activities Director, Employee E7, conducted on January 29, 2025, at 11:45 a.m., revealed that she was "filling in for the receptionist on January 23, 2025, from 2:00 p.m. to 10:00 p.m." and that she had not seen the resident in the foyer "at all" prior to Resident R1's elopement.</p> <p>Interview with Central Supply Staff, Employee E3, on January 30, 2025, at 1:14 p.m. revealed that she had "put the wander guard on Resident R1" upon admission, on January 20, 2025, at approximately 4:00 p.m. Employee E3 stated, "I got into the elevator from ground; the elevator wouldn't move so I reset the alarm and walked up the 3rd floor and put it on him." Further interview revealed, "the elevator wouldn't move so that was my way of knowing because the alarm is inside the elevator."</p> <p>Follow-up interview with the facility Nursing Home Administrator and Director of Nursing conducted on</p>	F 0689		

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F 0689 SS=J	Continued from page 8 January 31, 2025, at 10:19 a.m. revealed that the wander guard must be "checked" by a "tester box" which is not available at the facility and is "on order." Review of Resident R1's entire clinical record failed to reveal an order for a wander guard. Further review of Resident R1's clinical record failed to reveal documented evidence confirming that the wander guard was tested before application and upon residents return; and that the device was checked for placement each shift and checked for functionality daily by nursing staff. Interview with the Nursing Home Administrator and Director of nursing confirmed this finding on January 31, 2025, at 11:13 a.m. Based on the above findings, an Immediate Jeopardy to the safety of the resident was identified for failure to provide adequate supervision of Resident R1 who was identified as an elopement risk by the facility. This resulted in Resident R1 exiting the third floor via elevator and walked out of the front entrance of the facility. The resident was	F 0689		

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F 0689 SS=J	Continued from page 9 not able to be located for over 24 hours. An Immediate Jeopardy template (a document which included information necessary to establish each of the key components of immediate jeopardy) was provided to the Nursing Home Administrator (NHA) on January 30, 2025, at 11:07 a.m. On January 24, 2025, the facility initiated a plan of correction to address the failure of ensuring that a resident was adequately supervised to prevent elopement. The facility plan of correction included the following: 1. Resident left the Center. The Philadelphia Police Department and guardian were notified. The resident returned to the Center on January 25th from, an all-male boarding home, where he resided previously. 2. The Center completed a headcount of all residents and compared it to the midnight census to ensure all residents were accounted for and resting comfortably. Completed 1/23/2025.	F 0689		

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F 0689 SS=J	Continued from page 10 3.Immediate Actions/Education a. The Nursing Administration reviewed all resident EHR (Electronic Health Record) for accurate elopement/wandering evaluations, orders for every shift placement checks, daily function tests and care plans. The elopement book found at reception desk was reviewed to ensure that all residents identified as elopement risks were current, and resident identifiers were available. Completed 1/23/2025 b. Staff were educated on the implementation of resident specific interventions to prevent elopement. 92% completed 1/24/2025. The remainder was completed prior to the start of the next shift. c. Staff were educated on the procedure for elopement monthly drills and the announcement of code YELLOW to notify all staff. 92% completed 1/24/2025. The remainder was completed prior to the start of the next shift.	F 0689		

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F 0689 SS=J	Continued from page 11 d. RN Supervisors were educated on the completion of headcount of all residents compared to midnight census and the immediate reporting of any discrepancy to the Director of Nursing/designee. 92% completed 1/24/2025. The remainder was completed prior to the start of the next shift. e. Staff were educated on signs and symptoms that may indicate a risk of elopement. 92% completed 1/24/2025. The remainder was completed prior to the start of the next shift. f. Reception/off shift staff were educated on the process of each visitor receiving a badge that must be returned prior to door being opened and visitor leaving the premise. 92% completed 1/24/2025. The remainder was completed prior to the start of the next shift. Staff educated on elopement/missing person policy and procedure including code yellow announcement to notify staff in Center, search both on the premises and the surrounding areas, notification processes including local police	F 0689		

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F 0689 SS=J	Continued from page 12 department. 92% completed 1/24/2025. The remainder was completed prior to the start of the next shift. g. Staff educated that elopement devices are checked daily for functionality and every shift for placement by the professional nursing staff. 92% completed 1/24/2025. The remainder was completed prior to the start of their next shift. h. Staff educated on elopement drills including how often and expected response. 92% completed 1/24/2025. The remainder completed prior to the start of the next shift. i. All the training above will be added to our general orientation schedule for all new future employees. 92% completed 1/24/2025. The remainder was completed prior to the start of the next shift. The low voltage contractor responded to the Center immediately and changed the settings on front door requiring guest services staff to allow all visitors entrance and exit by hitting a button under the desk.	F 0689		

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F 0689 SS=J	Continued from page 13 Completed 1/23/2025 j. Testing box ordered. Completed 1/27/2025 k. Nursing Administration was educated on their responsibility to apply all new elopement devices and obtain and input orders for functionality and placement into the EHR. 4. Ongoing Compliance will be monitored by: a. Auditing census compared to headcount every 4HRS for 3 days then every shift for 14 days then daily. All variances will be reported to the QAPI Committee monthly. b. Random audit of five visitors to ensure compliance with the visitor pass system two times daily for 14 days then daily for two months. All variances will be reported to the QAPI Committee monthly. c. Random audit of 10 new admissions weekly to	F 0689		

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F 0689 SS=J	Continued from page 14 ensure thorough evaluation and care planning. All variances will be reported to the QAPI Committee monthly. d. The QAPI Committee will make recommendations to ensure continued compliance. Upon sustained compliance, the QAPI Committee will recommend the reduction or resolution of the audits. A review was conducted of staff education, resident elopement/wandering evaluations, function of front door, and test box order slip related to Resident R1's elopement. Interviews with facility staff were conducted on January 31, 2025. Facility staff provided extensive feedback and understanding of the facility's Elopement policy and process. Facility staff stated that wander management system devices will be checked for placement each shift, and for functionality daily by nursing staff. Review of facility documentation revealed that the corrective action plan was immediately initiated on	F 0689		

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F 0689 SS=J	Continued from page 15 January 24, 2025. The facility's action plan was accepted on January 31, 2025, at 1:24 p.m. and identified as past non-compliance. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services	F 0689		

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F 0835 SS=D		F 0835		

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(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 0835 SS=D	Continued from page 17 483.70 Administration §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 0835	"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report." Resident has been assessed and identified as elopement risk resident is being maintained on 1:1 supervision 24/7 A full house audit was completed to identify any other residents similarly affected. All variances were updated and discussed with the physician. Care plans were updated to address safety and supervision RDO reviewed with the NHA his respective job description that includes "Equipment and Supply Function" section stated that the NHA are to ensure that the Center is maintained in a clean and safe manner for residents' comfort and convenience by assuring that	Completion Date: 02/13/2025 Status: APPROVED Date: 02/13/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395485	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/31/2025
NAME OF PROVIDER OR SUPPLIER: GRADUATE POST ACUTE STATE LICENSE NUMBER: 200402		STREET ADDRESS, CITY, STATE, ZIP CODE: 1526 LOMBARD STREET PHILADELPHIA, PA 19146		
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F 0835 SS=D	Continued from page 18	F 0835	<p>necessary equipment and supplies are maintained to perform such duties/services. Ensure that adequate supplies and equipment are on hand to meet the day-to-day operations needs of the Center and residents.</p> <p>NHA reviewed with DON her respective job description which includes that the purpose of the position was to plan, organize, develop and direct the overall operation of the nursing service department in accordance with current federal, state and local standards, guidelines and regulations that govern our Center and as may be directed by the Administrator and the Medical Director, to ensure that the highest degree of quality care is maintained at all times. The Director of Nursing Services delegates the administrative authority, responsibility and accountability necessary for carrying out assigned duties.</p>	

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F 0835 SS=D	Continued from page 19 Based on review of clinical record, review of job's descriptions and interviews with staff, it was determined that the Nursing Home Administrator and Director of Nursing did not effectively manage the facility to ensure that adequate supervision was provided to on one of one resident reviewed (Resident R1) at risk for elopement. This failure resulted in Resident R1 exiting the third floor via elevator and walking out the front entrance doors. Resident R1 was unable to be located for over 24 hours. This failure placed the resident at high risk for injury and was identified as an Immediate Jeopardy of past non-compliance. (Resident R1) Findings include: Review of the Nursing Home Administrator's (NHA) job description revealed that the purpose of this position is to direct the day-to-day functions of the Center in accordance with current federal, state, and local standards, guidelines and regulations that govern nursing Centers to assure that the highest	F 0835		

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F 0835 SS=D	Continued from page 20 degree of quality care can be provided to our residents at all times. Continued review of the Nursing Home Administrator job description under "Equipment and Supply Function" section stated that the NHA are to ensure that the Center is maintained in a clean and safe manner for resident comfort and convenience by assuring that necessary equipment and supplies are maintained to perform such duties/services. Ensure that adequate supplies and equipment are on hand to meet the day-to-day operations needs of the Center and residents. Review of the Director of Nursing's job description revealed that the purpose of the position was to plan, organize, develop and direct the overall operation of the nursing service department in accordance with current federal, state and local standards, guidelines and regulations that govern our Center and as may be directed by the Administrator and the Medical Director, to ensure that the highest degree of quality care is maintained at all times. The Director of Nursing Services delegate the administrative authority, responsibility and	F 0835		

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F 0835 SS=D	Continued from page 21 accountability necessary for carrying out assigned duties. Review of Resident R1's nursing notes revealed that the resident was admitted on January 20, 2025, with past medical history of stroke, Schizophrenia with prior psychosis (a collection of symptoms where a person has trouble distinguishing between what is real and what is not) and intermittent agitation, cognitive dysfunction. During interview with Licensed Nurse, Employee E6, on January 30, 2025, at 10:40 a.m. Employee E6 indicated that the resident was at risk for elopement. Continued interview with Employee E6 confirmed that an elopement care plan was developed/initiated January 21, 2025. Review of Resident R1's care plan revealed a care plan date-initiated January 21, 2025, which indicated that the resident was at "actual / potential risk for elopement r/t (related to) adjustment reactions, cognitive impairment, New environment,	F 0835		

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F 0835 SS=D	Continued from page 22 non-acceptance of long-term placement." Review of nursing note for Resident R1 revealed a nurse's note, dated January 23, 2025, at 10:36 p.m. which indicated that when the Nurse Assistant entered Resident R1's room to deliver his dinner tray, she noted that Resident R1 was not present. The Nurse aide searched the unit for Resident R1 and immediately notified nursing administration; a search of all areas of the facility was performed. Further review revealed a nursing note dated, January 25, 2025, at 2:49 a.m. (over 48 hours since January 23, 2025, when the resident was noted missing) which indicated that the resident "arrived to the unit with the Director of Nursing." Upon arrival, Resident R1 was escorted to their room and assessed. Due to respiratory concerns, Resident R1 was sent to the Emergency Room for further evaluation. Resident R1 returned to the facility shortly after and was placed under one-to-one supervision.	F 0835		

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F 0835 SS=D	<p>Continued from page 23</p> <p>Review of nursing note dated January 25, 2025, at 7:35 a.m. indicated that the resident returned from hospital Emergency Room "1:1 protocol was instituted. Resident continues 1:1 care for elopement risk."</p> <p>Review of facility documentation reported to the State Survey Agency on January 23, 2025, at 6:30 a.m. revealed that Resident R1 was last seen by staff at 3:00 p.m. It was determined that Resident R1 took the elevator from the third-floor nursing unit and exiting through the doors of the main entrance of the facility. On January 25, 2025, at 12:21 a.m. the Director of Nursing, Employee E2 received a call from a nearby center stating that the resident came to their facility. Resident R1 returned to the nursing facility on January 25, 2025, at 2:49 p.m.</p> <p>Review of internet maps revealed that the center in which the resident was located was 2.2 miles, approximately a fifty-minute walk, from the nursing facility, in a busy urban area.</p>	F 0835		

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F 0835 SS=D	Continued from page 24 Interview with the Activities Director, Employee E7, conducted on January 29, 2025, at 11:45 a.m., revealed that she was "filling in for the receptionist on January 23, 2025, from 2:00 p.m. to 10:00 p.m." and that she had not seen the resident in the foyer "at all" prior to Resident R1's elopement. Interview with Central Supply Staff, Employee E3, on January 30, 2025, at 1:14 p.m. revealed that she had "put the wander guard on Resident R1" upon admission, on January 20, 2025, at approximately 4:00 p.m. Employee E3 stated, "I got into the elevator from ground; the elevator wouldn't move so I reset the alarm and walked up the 3rd floor and put it on him." Further interview revealed, "the elevator wouldn't move so that was my way of knowing because the alarm is inside the elevator." Follow-up interview with the facility Nursing Home Administrator and Director of Nursing conducted on January 31, 2025, at 10:19 a.m. revealed that the wander guard must be "checked" by a "tester box" which is not available at the facility and is "on order."	F 0835		

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F 0835 SS=D	Continued from page 25 Review of Resident R1's entire clinical record failed to reveal an order for a wander guard. Further review of Resident R1's clinical record failed to reveal documented evidence confirming that the wander guard was tested before application and upon residents return; and that the device was checked for placement each shift and checked for functionality daily by nursing staff. Interview with the Nursing Home Administrator and Director of nursing confirmed this finding on January 31, 2025, at 11:13 a.m. Based on the deficiencies identified in this report, the Nursing Home Administrator and Director of Nursing failed to fulfill essential duties and responsibilities of their position to ensure that the Federal and State guidelines and Regulations were followed, contributing to the Immediate Jeopardy situation. Refer to F689	F 0835		

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F 0835 SS=D	Continued from page 26 28 Pa. Code: 201.18(b)(1) Management 28 Pa. Code: 201.18(b)(3) Management	F 0835			



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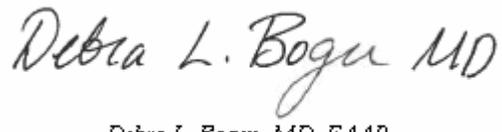
GRADUATE POST ACUTE

STATE LICENSE NUMBER: 200402

SURVEY EXIT DATE: 01/31/2025

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**

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PLEASE DO NOT DETACH

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