STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395662	A. BLDG: 00 B. WING:	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
LOGAN SQUARE REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **127502**	**TWO FRANKLIN TOWN BOULEVARD PHILADELPHIA, PA 19103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance survey and an Abbreviated survey in response to two complaints, completed January 15, 2025, it was determined that Logan Square Rehabilitation and Healthcare Center, 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 0000		
F 0558 SS=D		F 0558		

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 0558 SS=D	Continued from page 1 483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:	F 0558	1) Resident 215 and Resident 165 were both provided appropriate bed size with appropriate length. 2) Current residents that are taller than 6ft have been audited by the Maintenance director/designee to ensure that the bed size is appropriate for resident. 3) The Maintenance Director will be educated by the Nursing Home Administrator / designee on appropriate bed size and extensions available for residents. 4) Random audits of new admission and beds that are appropriate in length are put in place to meet residents' needs. Audits will be conducted weekly x 3 weeks, then monthly x 2 or until compliance is sustained. Variances will be addressed and reported to the QAA committee.	Completion Date: **02/20/2025** Status: **APPROVED** Date: **02/06/2025**

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F 0558 SS=D	Continued from page 2 Based on observations, review of clinical records, and staff interview it was determined that the facility failed to provide reasonable accommodation of needs for two of 30 residents reviewed (Resident R215 and R165). Findings Include: Review of Resident R215's clinical record revealed the resident was admitted to the facility on December 10, 2024. Height and weight measurements dated December 11, 2024, revealed Resident R215 was 6 feet 3 inches tall and weighed 225 pounds. Review of Resident R215's clinical record revealed a nursing note dated December 11, 2024, at 11:49 p.m. that a TELS (an electronic system used to enter, manage, and track maintenance requests) request was placed for a bed extender (increases the length and/or width of existing bed to provide more space and comfort).	F 0558		

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F 0558 SS=D	Continued from page 3 During an interview on January 12, 2025, at 11:35 a.m. Resident R215 reported that the bed was too small (Resident R215 was too tall for the bed) causing his feet to press against the footboard while lying in bed and subsequently causing his feet to feel numb. Observations confirmed Resident R215 appeared uncomfortable in bed as he needed to keep his legs bent and pulled to the side to keep them from pressing against the footboard. Observations on January 12, 2025, at 11:35 a.m. revealed the width of the bed was also too small leaving little room for Resident R215 to reposition in bed. Resident R215 reported feeling fearful of falling out of bed when being turned and repositioned due to the little space and no bed enablers to hold onto. Interview on January 12, 2025, at 12:07 p.m. with Nursing Supervisor, Employee E3, confirmed the bed was too small for Resident R215 and that the facility was working on getting a bed extender for the resident's bed.	F 0558		

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F 0558 SS=D	Continued from page 4 Interview on January 12, 2025, at 12:12 p.m. with Nursing Home Administrator, Employee E1, confirmed the facility was still working on getting the resident a bed extender and was unsure why a proper fitting bed was not available on the day Resident R215 was admitted. Observations on January 12, 2025, at 11:00 a.m. of Resident R165's room revealed the resident was laying on the bed. Residents foot was on top of the footboard with a pillow under the ankle area. Resident R165 stated the bed was short for him and he could not raise the head of the bed without placing foot on the bed. Further observation revealed that there was no bed extender placed on the bed. Interview with Administrator on January 12, 2025, at 2:00 p.m. stated facility could utilize bed extender for residents if the bed was short for them. Observation with Administrator confirmed that the bed for R165 was short and he placed his foot on the foor board.	F 0558		

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F 0558 SS=D	Continued from page 5 28 Pa. Code 201.29 (a) Resident Rights. 28 Pa. Code 211.10 (d) Resident care policies.	F 0558		
F 0583 SS=D	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident,	F 0583	1) Employee E8 has been educated on the facility policy for Personal Privacy / confidentiality of records 2) All residents have the potential to be affected. 3) Director of Nursing / designee will educate facility staff on the facility policy of resident personal privacy and confidentiality of records. 4) . Random audits of common areas will be conducted daily x 7days, weekly x 3 weeks then monthly x 2 or until compliance is met, Variances will be addressed and reported to the QAA committee.	Completion Date: **02/20/2025** Status: **APPROVED** Date: **02/06/2025**

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F 0583 SS=D	Continued from page 6 including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by:	F 0583		

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F 0583 SS=D	Continued from page 7 Based on observation and review of facility policy, it was determined that the facility failed to ensure that the residents right to privacy was protected for two of 30 residents reviewed. (Resident R Findings include: Review of facility policy titled "Confidentiality of Information and Personal Privacy" dated October 2017, revealed that the facility will safeguard the personal privacy and confidentiality of all resident personal and medical records. The facility will strive to protect the resident's privacy regarding his or her accommodations, medical treatment, written communication, personal care, visits, and family group meetings. Observation on the third floor activity room on January 13, 2025 at 10:53, the room included eleven residents and two employees, Registered nurse, Employee E8 was observed evaluating a	F 0583		

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F 0583 SS=D	Continued from page 8 resident's vital signs. registered nurse Employee E8 was overheard relaying the vital measurements to the resident. 28 Pa. Code 201.18(b)(2) Management	F 0583		
F 0641 SS=A		F 0641		

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F 0641 SS=A	Continued from page 9 483.20(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	I hereby acknowledge the CMS 2567-A, issued to LOGAN SQUARE REHABILITATION AND HEALTHCARE CENTER for the survey ending 01/15/2025, AND attest that all deficiencies listed on the form will be corrected in a timely manner.	Completion Date: **02/20/2025** Status: **APPROVED** Date: **02/06/2025**

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F 0641 SS=A	Continued from page 10 Based on clinical record review and interview with staff, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for one of 30 residents reviewed (Residents R24). Findings include: Clinical record review revealed Resident R24 was admitted to the facility on December 3, 2024, with a diagnosis that included metabolic encephalopathy (condition in which brain function is disturbed due to underlying diseases or toxins in the body), acute kidney failure (kidneys stop working suddenly), and acute pyelonephritis (sudden and severe inflammation of kidney due to bacterial infection). Further review of Resident R24's clinical record revealed Resident R24 was admitted with an indwelling catheter on December 3, 2024. Review of Resident R24's most recent nursing note dated January 15, 2024 revealed Resident R24	F 0641		

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F 0641 SS=A	Continued from page 11 continues to have an indwelling catheter in place and receives daily catheter care. Review of Resident R24's MDS (MDS-minimum data set, a ferally required resident assessment completed at a specific interval), dated December 10, 2024, revealed under section Bowel and Bladder that Resident R24's catheter status was coded "No". Interview with Employee E2, Director of Nursing, conducted on January 15, 2024 at 2:10 p.m. confirmed that Resident R24's catheter status was coded incorrectly. 28 Pa. Code 201.14(a) Responsibility of licensee 2 Pa. Code 211.5(f) Medical records	F 0641		

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F 0655 SS=D	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions.	F 0655	1) Resident R164 and their resident representative was provided with a written summary of the baseline care plan. 2) Current residents admitted in the past 30 days will be audited to ensure compliance with baseline care plans. Any variances will be addressed. 3) Administrator / designee will educate social services staff on baseline care plan policy. 4) Social Service Director / designee will conduct audits of new admissions to ensure compliance with baseline care plans policy. Audits will be completed weeky x 3, then monthly x 2 or until compliance is met, Variances will be addressed and reported to The QAA Committee.	Completion Date: **02/20/2025** Status: **APPROVED** Date: **02/06/2025**

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F 0655 SS=D	Continued from page 13 (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by:	F 0655		

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F 0655 SS=D	Continued from page 14 Based on review of clinical records, staff and resident interviews, it was determined that the facility failed to ensure that a written summary of the baseline care plan was provided to the resident and/or the resident's representative that included initial goals based on admission orders, physician orders, therapy services and social services for one of 22 residents reviewed (Resident R164). Findings include: Review of clinical record revealed that the resident was admitted to the facility on January 2, 2025, with diagnosis including progressive neurological condition and cerebrovascular accident (stroke) and Parkinson's disease (progressive disease of the central nervous system). Interview with Resident R164 and with resident's family on January 12, 2025 at 11:25 a.m. stated she was admitted to the facility 9 days ago and she was not sure if she was getting all her medications. Continued interview with Resident R164 and	F 0655		

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F 0655 SS=D	Continued from page 15 resident's family stated they were not provided a written summary of the baseline care plan that included initial goals based on admission orders, physician orders, therapy services and social services. Review of the care plan and the clinical record revealed no documented evidence that the resident representative received a written summary of the baseline care plan that included initial goals based on admission orders, physician orders, therapy services and social services. . A request was made to the Social Service Director on January 15, 2025, at 11:44 a.m., for a copy of the baseline care plan for Resident R164 and evidence that resident/resident representative received a copy of the baseline care plan. Interview with Social Service Director on January 15, 2025, at 11:44 a.m., stated facility did not conduct a baseline care plan meeting with Resident R164 and a written summary of the baseline care	F 0655		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0655 SS=D	Continued from page 16 plan was provided to the resident and/or the resident's representative. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services	F 0655		
F 0755 SS=D		F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395662	A. BLDG: 00 B. WING:	01/15/2025

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F 0755 SS=D	Continued from page 17 483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 0755	1) Resident 34 medication is now available from pharmacy. 2) Current residents ordered anticoagulants will be audited to ensure availability of medication from pharmacy. Variances to be addressed. 3) Director of Nursing / Designee will educate licensed nursing staff on facility medication availability policy and procedures. 4) Director of nursing / Designees will conduct audits weekly x 3 , then monthly x 2 or until compliance is met to ensure compliance with med availability policy. Variances will be addressed and reported to The QAA Committee	Completion Date: **02/20/2025** Status: **APPROVED** Date: **02/06/2025**

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F 0755 SS=D	Continued from page 18 This REQUIREMENT is not met as evidenced by:	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0755 SS=D	Continued from page 19 Based on review of facility policy, review of clinical records, and staff interview, it was determined that the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring and administering of medications) to meet the needs of each resident for one of 22 residents reviewed (Resident R34). Findings Include: Review of facility policy "Unavailable Medication" dated June 2021 revealed in conjunction with the contracted pharmacy, the facility will make every effort to ensure that a medication ordered for the resident is available to meet their needs. Continued review of facility policy "Unavailable Medication" revealed in the event that a medication ordered for a residents is noted to be unavailable near or at the time it is to be dispensed, nursing staff shall contact the pharmacy regarding the unavailable medication, attempt to obtain the medication from the facility's automated medication dispensing	F 0755		

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F 0755 SS=D	Continued from page 20 system, notify the physician of the unavailable medication, report the date of the expected delivery, and obtain new orders. Review of Resident R34's admission Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated December 21, 2024, revealed the resident was cognitively intact and had diagnoses of polycythemia vera (a rare blood cancer that causes too many red blood cells, thickening the blood and increasing the risk of blood clots) and atrial fibrillation (an irregular heart rhythm that can lead to stroke, heart failure and other complications). Further review of the MDS revealed Resident R34 was taking an anticoagulant (also referred to as a blood thinner - medications that reduces the formation of blood clots). Review of Resident R34's care plan dated December 18, 2024, revealed the resident was on anticoagulant therapy for blood clot prevention. Intervention dated December 18, 2024, included to provide medication as ordered.	F 0755		

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F 0755 SS=D	Continued from page 21 Review of Resident R34's medication administration record revealed Warfarin 2.5 mg (milligrams) (an anticoagulant medication) was due in the evening on January 4, 2025. The medication was signed out as "drug/treatment not administered". Review of Resident R34's clinical record revealed a medication administration note for the Warfarin 2.5 milligerams (mg) dose due on January 4, 2025, that revealed "waiting on pharmacy". Review of Resident R34's clinical record revealed no documented evidence the nurse called the pharmacy to determine an expected delivery date and no documented evidence the physician was made aware of the missed medication and subsequent new orders on how to proceed. Further review of Resident R34's medication administration record revealed Warfarin 2mg was due in the evening on January 6, 2025, and January 12, 2025. The medications were signed out as "drug/treatment not administered" on both dates.	F 0755		

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F 0755 SS=D	Continued from page 22 Review of Resident R34's clinical record revealed a medication administration note for the Warfarin 2mg dose due on January 6, 2025, that revealed "awaiting pharmacy". Review of Resident R34's clinical record revealed a medication administration note for the Warfarin 2mg dose due on January 12, 2025, that revealed "awaiting pharm". Interview on January 15, 2025, at 10:48 a.m. with Registered Nurse, Employee E4, revealed missed medications were due to the pharmacy not delivering medications in a timely manner. 28 Pa. Code 211.9 (a)(1) Pharmacy services.	F 0755		

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F 0761 SS=E	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	1) Eye drops in both medication carts have been replaced and labeled correctly with date they were opened. 2) All Medication carts have been audited to ensure all eye drops have been dated upon opening. 3) Licensed nursing staff will be educated by Director of Nursing / designee on medication storage and labeling. 4) Director of Nursing / designee will conduct random audits of medication carts weekly x 3 , then monthly x 2 or until compliance is met to ensure proper medication storage and labeling on medication carts. Variances will be addressed and reported to the QAA Committee .	Completion Date: **02/20/2025** Status: **APPROVED** Date: **02/06/2025**

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F 0761 SS=E	Continued from page 24 Based on the observation, review of facility policy and procedure, review of manufacturers guidelines, and interviews with staff, it was determined that the facility failed to properly label medications upon opening for ophthalmic solutions found on two of three medications carts observed. (third floor carts one and two) Findings: Review of facility policy titled "Medication Labeling and Storage" revealed the facility stores all medications and biologicals under proper temperature, humidity, and light controls. Only authorized personnel have access to keys. The nursing staff is responsible for maintaining medications storage and preparation areas they clean safe and sanitary manner. Multi dose vials that have been opened or at accessed are dated and discarded within 28 days unless the manufacturer specifies a sure they're longer date for the open vial. Observation of medication pass with Employee	F 0761		

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F 0761 SS=E	Continued from page 25 Licensed nurse, Employee E5 on January 12, 2024, during med pass, inspection of third floor medication cart one revealed seven boxes of multi-use eye drops without any date written on the box of date of opening. Interview with Employee E5 at time of the above observation confirmed that seven boxes of multi-use eye drops did not contain the date of opening on the box. Observation of medication pass with Licensed nurse, Employee E6 on January 12, 2024, during med pass, inspection of third floor medication cart two revealed two boxes of multi-use eye drops without any date of opening on the box. Interview with Employee E6 at time of the above observation confirmed that the two boxes of multi-use eye drops did not contain the date of opening on the box.	F 0761		

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F 0761 SS=E	Continued from page 26 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d0(1) Nursing services	F 0761		
F 0810 SS=D		F 0810		

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F 0810 SS=D	Continued from page 27 483.60(g) Assistive Devices - Eating Equipment/Utensils §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by:	F 0810	1) Resident R83 was immediately provided with their assistive devices. 2) Current residents who are ordered assistive devices with meals have been audited to ensure assistive devices are available for use. 3) Dietary director / designee will educate dietary staff on ensuring assistive devices are provided to any resident indicated for such. 4) Dietary director / designee will complete random audits to ensure identified residents are provided with ordered assistive devices. Audits will be completed weekly x 3 monthly x 2 or until compliance is met. Variances will be addressed and reported to the QAA Committee.	Completion Date: **02/20/2025** Status: **APPROVED** Date: **02/06/2025**

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F 0810 SS=D	Continued from page 28 Based on review of facility policy, review of clinical records, observations and staff interviews, it was determined the facility failed to provide adaptive equipment for 1 of 18 residents observed during dining on the third-floor dining room. Findings: Policy titled "Assistive Devices and Equipment" revealed the facility maintains and supervises the use of assisted devices and equipment for residents. Devices and equipment that assist with residents' mobility, safety and independence are provided for residents these may include but are not limited to specialized eating utensils and equipment. Recommendations for the use of devices and equipment are based on comprehensive assessment and documented in the residence care plan. Staff and volunteers are trained to demonstrate competency in the use of devices and equipment prior to assisting or supervising residents. Review of Residents R83's quarterly minimum data	F 0810		

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F 0810 SS=D	Continued from page 29 set (mds- a federal mandated assessment tool for all residents) dated December 9, 2024. Resident R83 entered the facility June 30 2023 with diagnosis' including malnutrition(imbalance between the nutrients the body needs to function and the nutrients it gets), hemiplegia (paralysis or weakness to one side of the body), aphasia (loss of ability to understand or express speech), stroke (a condition in which poor blood flow to the brain and caused cell death). Resident R83 has been assessed as having a brief interview mental for mental status) score of three, indicating that resident R83 has severe cognitive impairment. Review of resident's physicians order dated January 4, 2024, revealed an order for buildup utensils with meals. Interview with Resident R83's family on January 12, 2024 at 12:05 p.m. in the third-floor dining room revealed that resident is supposed to have special utensils but was not given them. She said she asked a staff member for them but has not received them.	F 0810		

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F 0810 SS=D	Continued from page 30 Observation of lunch third floor January 12, 2025, at 12:10 p.m. rrevealed Rsident R83 has order for step up utensils, observed at lunch the resident given regular utensils. Interview with Nurse aide, Employee E8 confirmed that resident is supposed to be given build up utensils and has not received them at this meal. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12 (d)(1) Nursing services	F 0810		
F 0868 SS=D		F 0868		

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F 0868 SS=D	Continued from page 31 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) QAA Committee §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member	F 0868	1) QAPI meeting has been held with appropriate attendees signatures obtained. 2) Past 3 months QAPI will reviewed to determine appropriate staff members that were missing. The NHA / designee will review the past three months of QAPI meeting minutes with the Director of Nursing. 3) NHA and Director of nursing will be educated by the Regional Clinical Consultant / Designee on Facility QAPI policy and ensuring appropriate staff members present. 4) Monthly QAPI will be audited for three months for appropriate staff member attendance. Variances will be addressed and reported to the QAA Committee.	Completion Date: **02/20/2025** Status: **APPROVED** Date: **02/06/2025**

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F 0868 SS=D	Continued from page 32 of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by:	F 0868		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
LOGAN SQUARE REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **127502**	**TWO FRANKLIN TOWN BOULEVARD PHILADELPHIA, PA 19103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0868 SS=D	Continued from page 33 Based on review of facility documents of Quality Assurance meeting attendance and staff interviews, it was determined that the facility failed to ensure that the Director of Nursing Services attended a quarterly Quality Assurance Process Improvement (QAPI) committee meeting for nine of nine QAPI meeting documentations reviewed (February 2024 through October 2024). Findings Include: A review of QAPI committee meeting attendees list for the month of February 2024, March 2024, April 2024, May 2024, June 2024, July 2024, August 2024, September 2024 and October 2024 revealed that it lacked Director of Nursing as attendee for the meetings. This information was confirmed by the facility Regional Staff during a meeting on January 15, 2025, at 1:13 p.m. Facility documentation provided at the time of the survey did not have evidence that the director of nursing attended the meetings.	F 0868		

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F 0868 SS=D	Continued from page 34 There was no sign in sheet or meeting minutes information available for July of 2024 that any of the required members attended the meeting. Facility did not provide this information at the time of the survey. A request for copies of the original QAPI sign in sheet provided at the time of the survey was requested however was not submitted. 28 Pa. Code 201.18 (1)(3) Management.	F 0868		
F 0883 SS=D		F 0883		

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F 0883 SS=D	Continued from page 35 483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 0883	1) Resident R34 and Resident R315 were both offered the influenza vaccine. 2) Residents admitted during the last 30 days will be audited to ensure influenza vaccine has been offered. Variances will be addressed. 3) Director of nursing / designee will educate admissions nurse, assistant director of nursing, infection preventionist, clinical nurse leads and supervisors to ensure all new residents vaccine history is reviewed for influenza vaccine administration and offered influenza vaccine on admission if appropriate. 4) Audits will be conducted weekly x 3, then monthly x 2 on new admissions to ensure influenza vaccines are offered if appropriate, until compliance is met. Variances will be addressed, and reported to the QAA Committee.	Completion Date: **02/20/2025** Status: **APPROVED** Date: **02/06/2025**

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F 0883 SS=D	Continued from page 36 (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:	F 0883		

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F 0883 SS=D	Continued from page 37 Based on review of facility policy, review of clinical records, and staff and resident interviews, it was determined that the facility failed to ensure that each resident was offered an influenza immunization for two of seven residents reviewed for immunizations (Resident R34 and R315). Findings Include: Review of Resident R34's admission Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated December 21, 2024, revealed the resident was admitted to the facility on December 17, 2024, and was cognitively intact. Interview on January 14, 2025, at 1:38 p.m. with Resident R34 the resident denied being offered the influenza immunization on admission but admitted being willing to accept the vaccine if suggested by the physician. Review of Resident R34's entire clinical record, including immunization history, revealed no	F 0883		

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F 0883 SS=D	Continued from page 38 documented evidence the resident was offered the immunization on admission or documentation that the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. Review of Resident R315's admission Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated December 17, 2024, revealed the resident was admitted to the facility on December 11, 2024, and was cognitively intact. Interview conducted on January 13, 2025 at 10:35 p.m. with Resident R315 revealed the facility did not offer the resident the influenza immunization on admission. Resident R315 stated she has been requesting the influenza immunization and would like to receive it before discharge Review of Resident R315's entire clinical record, including immunization history, revealed no	F 0883		

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F 0883 SS=D	Continued from page 39 documented evidence the resident was offered the immunization on admission or documentation that the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. 28 Pa. Code 211.5 (f)(iv) Medical records. 28 Pa. Code 211.12(d)(1) Nursing services	F 0883		
F 0921 SS=D		F 0921		

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F 0921 SS=D	Continued from page 40 483.90(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	1) Overhead light for resident R164 was fixed. IV pole for Resident R220 was cleaned. 2) Facility wide audit of current resident who are ordered IV medication where checked for cleanliness, variances were addressed. A facility wide audit was also completed of all resident rooms to ensure that all overhead lights had strings that were appropriate in length to meet the need of the residents. Variances were addressed. 3) Maintenance director / designee will educate maintenance department staff members on ensuring broken overhead lights are fixed timely. Housekeeping director / designee will educate housekeeping department staff members on ensuring proper cleanliness of IV poles. 4) Random room audits will be conducted weekly x 3, then monthly x 2 or until compliance is met to cleanliness of iv pole and overhead	Completion Date: **02/20/2025** Status: **APPROVED** Date: **02/06/2025**

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F 0921 SS=D	Continued from page 41	F 0921	lights are in proper working order. Variances will be addressed and reported to the QAA committee	

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F 0921 SS=D	Continued from page 42 Based on observations, review of clinical record, and staff and resident interviews it was determined that the facility failed to provide a sanitary and comfortable environment for two of 30 residents reviewed (Resident R220 and R164). Findings Include: Review of Resident R220's clinical record revealed a physician order dated January 1, 2024, for an antibiotic medication to be administered intravenously (medical technique that administers medications directly into the vein) one time per day. Observations on January 15, 2024, at 11:56 a.m. with Director of Nursing, Employee E2, revealed Resident R220's IV pole (a device that holds a bag of intravenous fluids or medications in place as it is being administered to a patient) was soiled at the base of the pole with what appeared to be old tube feeding formula. Interview with Resident R164 and with resident's	F 0921		

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F 0921 SS=D	Continued from page 43 family on January12, 2025 at 11:25 a.m. stated she had an over the head light that would not turn off. She stated it was broken when she was admitted to the facility nine days ago. Resident stated she had been sleeping with the lights on for every day since her admission. Resident's family stated the cord that turns the light on and off did not work properly and the light did not turn off. Continued interview with Resident 164 stated some facility staff did try to fix it and left without fixing it. Observation of the over the head light revealed that the light string was broken and had only 2 inches left from the fixture. The light could not be turned off. Review of clinical record revealed that the resident was admitted to the facility on January 2, 2025 with diagnosis including progressive neurological condition and cerebrovascular accident(stroke) and Parkinson's disease. Interview with Administrator on January 12, 2025,	F 0921		

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F 0921 SS=D	Continued from page 44 at 2:00 p.m. confirmed that overhead light for Resident R164 was broken.	F 0921		

Certified End Page

LOGAN SQUARE REHABILITATION AND HEALTHCARE CENTER

STATE LICENSE NUMBER: 127502

SURVEY EXIT DATE: 01/15/2025

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

Jeanne Parisi
Deputy Secretary for Quality Assurance

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

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY