

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395722</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/27/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>UNIVERSITY CITY REHABILITATION AND HEALTHCARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>3609 CHESTNUT STREET PHILADELPHIA, PA 19104</b>		
STATE LICENSE NUMBER: <b>180102</b>				
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F 0000	INITIAL COMMENT	F 0000		
F 0554 SS=D	Based on a Medicare/Medicaid Recertification Survey, Civil Rights Compliance Survey, State Licensure Survey and an Abbreviated survey in response to a complaint, completed on Januray 27, 2025, it was determined that University City Rehabilitation and Healthcare Center, was not in compliance with the requirements of 42 CFR part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations related to the health portion of the survey process.	F 0554		

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 0554  SS=D	Continued from page 1  483.10(c)(7) Resident Self-Admin Meds-Clinically Approp  §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.  This REQUIREMENT is not met as evidenced by:	F 0554	<ol style="list-style-type: none"> <li>1. R114 eye drops at bedside have been removed. R12 hydrocortisone cream was removed. No adverse effects were noted.</li> <li>2. An initial audit was conducted to ensure medication is not at any residents bedside unless self administration evaluation was completed and residents were deemed safe to self administer. Variances were addressed at the time of the audit and placed on the facility audit tool</li> <li>3. Licensed nursing staff were educated by DON/designee on policy of medication at bedside and self-administration.</li> <li>4. DON/Designee will conduct audit on medication at bedside which will be completed 3 times per week for 4 weeks then 1 time a month for 2 months. Audit findings will be addressed and submitted to the Quality Assurance Performance Improvement Committee for further review and recommendations as needed.</li> </ol>	Completion Date: <b>03/05/2025</b> Status: <b>APPROVED</b> Date: <b>02/18/2025</b>

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F 0554  SS=D	Continued from page 2  Based on observations, review of facility policies, clinical record reviews and interviews with residents and staff, it was determined that the facility failed to ensure that residents were evaluated for self-administration of medications for two of 30 residents reviewed (Residents R114 and R12).  Findings include:  Review of facility policy, "Self-Administration of Medications" dated February 2021, revealed, "Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so." Continued review revealed, "Residents who are identified as being able to self-administer medications are asked whether they wish to do so."  Observation on January 21, 2025, at 11:12 a.m. revealed that Resident R114 had two containers of eye drops at her beside; latanoprost ophthalmic solution 0.005% (treats glaucoma - damage to the	F 0554		

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F 0554  SS=D	Continued from page 3  optic nerve in the eye) and brimonidine tartrate ophthalmic solution 0.2% (treats glaucoma). Resident R114 stated that she feels the nursing staff do not consistently administer the medications at the same time everyday and that she wants to keep the medications at her bedside in order to maintain her home routine.  Review of Resident R114's clinical record revealed no indication that the resident was assessed for the capacity and ability to safely administer her own medications.  Observation on January 22, 2025, at 10:29 a.m. revealed that Resident R12 had a tube of hydrocortisone cream (medication used to relieve itching) at her bedside. Resident R12 stated that she wants to keep the medication at her bedside to use on herself as needed due to a rash on her leg.  Review of Resident R12's clinical record revealed no indication that the resident was assessed for the capacity and ability to safely administer her own	F 0554		

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F 0554  SS=D	Continued from page 4  medications.  Observation and interview on January 23, 2025, at 4:21 p.m. Employee E6, licensed nurse, confirmed that Resident R114 had the two bottles of eyedrops at her bedside and that there was no physician's order or evaluation that the resident was assessed to safely self-administer the medications.  Continued observation and interview with Employee E6, licensed nurse, confirmed that there was no physician's order or evaluation that Resident R12 was assessed to safely self-administer her medication.  28 Pa Code 201.29(a) Resident rights  28 Pa Code 211.9(b) Pharmacy services	F 0554		
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F 0578  SS=D	Continued from page 5  483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir  §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.  §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.  §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance	F 0578	1. R86 POLST form and order were updated and accurately reflect the residents' wishes. 2. An initial audit was conducted to ensure all POLST forms and physicians orders match per residents wishes. Variances were addressed at the time of the audit and placed on the facility audit tool  3. Social Services and licensed nursing staff were educated by DON/designee to ensure POLST form and orders coincide. 4. DON/Designee will conduct an audit on POLST forms/physicians orders for advanced directives 3 times per week for 4 weeks then 1 time per month for 2 months. Audit findings will be addressed and submitted to the Quality Assurance Performance Improvement Committee for further review and recommendations as needed.	Completion Date: <b>03/05/2025</b> Status: <b>APPROVED</b> Date: <b>02/18/2025</b>

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F 0578  SS=D	Continued from page 6  directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.  This REQUIREMENT is not met as evidenced by:	F 0578		

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F 0578  SS=D	Continued from page 7  Based on review of facility policies, clinical record reviews and interviews with staff, it was determined that the facility failed to ensure that a resident's right to request or refuse medical treatments were accurately reflected in the resident's record for one of 30 residents reviewed (Resident R86).  Findings include:  Review of facility policy, "Advance Directives" dated September 2022, revealed, "The resident has the right to refuse medical or surgical treatment, whether or not he or she has an advance directive."  Review of physician's orders for Resident R86 revealed an order, dated June 27, 2024, for "Advance Directives: Full Code" (allows for all interventions needed to restore breathing or heart functioning, including chest compressions, a defibrillator and insertion of a breathing tube).  Review of Resident R86's care plan, dated initiated May 24, 2024, revealed, "I do not have an	F 0578		

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F 0578  SS=D	Continued from page 8  advanced care directive: Full Code."  Review of Resident R86's POLST form (Pennsylvania Orders for Life-Sustaining Treatment), dated and signed by the resident on March 27, 2023, revealed that the resident does not want lifesaving interventions in the event the resident has no pulse and had stopped breathing (DNR status - Do Not Resuscitate).  Interview on January 24, 2025, at 12:07 p.m. Employee E5, licensed nurse, confirmed that Resident R86's wishes regarding life saving medical treatments were not accurately reflected in his clinical record and that she would have to clarify them with the resident and physician.  28 Pa Code 201.29(a) Resident rights  28 Pa Code 211.5(f)(vii) Medical records	F 0578		

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F 0600  SS=D	Continued from page 10  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	"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."  1. R37 and R77 were separated at the time of the incident with no more physical interactions. 2. An initial audit was conducted for past 30 days of resident-to-resident altercations to ensure proper interventions are in place to prevent abuse. Variances were addressed at the time of the audit and placed on the facility audit tool 3. NHA/Designee will educate all staff on abuse prevention policy and procedures 4. NHA/Designee will conduct an audit of all resident to resident abuse altercations 3 times per week for 4 weeks then 1 time per month for 2 months to ensure proper interventions/preventions were in	Completion Date: <b>03/05/2025</b> Status: <b>APPROVED</b> Date: <b>02/18/2025</b>

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F 0600  SS=D	Continued from page 11	F 0600	place to prevent. Audit findings will be addressed and submitted to the Quality Assurance Performance Improvement Committee for further review and recommendations as needed.	

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F 0600  SS=D	Continued from page 12  Based on review of facility policy, review of clinical record, review of facility documentation, and interviews with staff, it was determined the facility failed to to ensure that residents were free from resident to resident abuse for two of 30 residents reviewed. (Resident R77)  Findings include:  Review of facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program," revised April 2021, revealed that Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation..." The program's objective is to maintain care "for all residents and particularly those with behavioral, cognitive or emotional problems."  Review of information dated August 4, 2024, and submitted to the state Survey Office on August 4, 2024, indicated, "Resident R77 (BIMS 9) was in the dining room during dinner and another resident, Resident R37, started to hit Resident R77 in the left	F 0600		

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F 0600  SS=D	Continued from page 13  arm with her cane because she stated that Resident R77 "always tries to eat her food."  Review of Resident R77's clinical record revealed an admission date of October 8, 2020, with diagnoses including cognitive communication deficit, anxiety disorder, and muscle weakness. Review of Minimum Data Set (assessment of resident needs) dated May 2, 2024, revealed a BIMS (Brief Interview of Mental Status) score of 9 indicating moderate cognitive impairment.  Review of Resident R37' s clinical record revealed an annual MDS dated May 10, 2024, revealed a BIMS score of 14 indicating that the resident was cognitively intact.  Review of facility investigation revealed a written statement by Registered Nurse, Employee E23, undated, which indicated, "this nursing supervisor was made aware that Resident R77 (male stealing food)) was hit with a cane by Resident R37 (female) during dinner. Resident R77 took food off Resident	F 0600		

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F 0600  SS=D	Continued from page 14  R37's tray."  Review of statement, undated, by Nurse Assistant, Employee E22 indicated, "I was passing out trays when I heard the commotion in the dining room. When I entered, I see Resident R77 sitting where the end table eating food. Then I see Resident R37 standing over him hitting him with her cane multiple times."  A review of another statement, undated and name undisclosed, indicated that "Resident R37 stated she had got up from her table when she came back Resident R77 was eating her food and she swung at him with her cane."  Further review of facility investigation failed to reveal a statement by Nurse Assistant, Employee E16 who was present in the dining room and witnessed the altercation.  Review of Resident R77's clinical records revealed a nursing progress note dated, August 4, 2024, at 5:53 p.m. which indicated, "upon hearing a loud call	F 0600		

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NAME OF PROVIDER OR SUPPLIER: <b>UNIVERSITY CITY REHABILITATION AND HEALTHCARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>3609 CHESTNUT STREET PHILADELPHIA, PA 19104</b>		
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F 0600  SS=D	Continued from page 15  from the Nursing Assistant during dinner in the dining room, I immediately entered the room. Resident R37 had hit resident with her cane on the left arm multiple times, expressing her frustration that he always tries to eat my food. The resident has a history of wandering and consuming other snacks for dinner."  Interview with Nurse assistant, Employee E18, conducted on January 24, 2025, at 11:24 a.m. revealed that she witnessed Resident R77 taking food that was not his, "at least" twice before the incident which occurred on August 8, 2024.  Interview with the Nurse Unit Manager, Employee E19, on January 24, 2025, at 11:24 a.m. revealed that prior to the incident, Resident R77 has portrayed behaviors such as "wandering around and taking peoples food."  Interview with Nurse Assistant, Employee E16, conducted on January 27, 2025, at 8:47 a.m. revealed that Resident R77 has taken food from the	F 0600		

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F 0600  SS=D	Continued from page 16  nursing station without permission in the past.  Interview with Licensed Practical Nurse, Employee E17, conducted on January 27, 2025, at 8:47 a.m. revealed, "I've seen him take food in the past that wasn't his" including from the refrigerator.  A telephone interview was conducted on January 27, 2025, at 8:47 a.m. with Nurse Assistant, employee E16, revealed that when Resident R37 got up from her table for ice, she witnessed Resident R77 sit in Resident R37's seat and began eating Resident R37's food. When Resident R37 returned, she began to hit Resident R77's hands with her cane, "and she couldn't stop."  A telephone Interview with Licensed Practical Nurse, Employee E17, conducted on January 27, 2025, at approximately 8:47 a.m. revealed that he ran into the dining room to provide help and witnessed Resident R37 hitting Resident R77 with her cane, on the hands. During the interview, Employee E17 stated, "nature of what I saw was on	F 0600		

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F 0600  SS=D	Continued from page 17  the hand."  A statement by Nurse Assistant Employee E16, was provided electronically by the facility administrator at the end of survey, on January 27, 2025, at 10:40 a.m.; however, the statement was undated and indicated that when Resident R37 went to get ice, Resident R77 began to eat her food. Upon Resident R37's return, Resident R37 "started hitting Resident R77 on his right hand ..."  Review of Resident R77's care plan date-initiated July 5, 2024, revealed resident was care planned for "wandering into other resident rooms getting into empty beds including the shower room." Further review of Resident R77's clinical record failed to reveal documented evidence of interventions, including a care plan for behaviors involving eating other residents' food without permission, prior to August 4, 2024. Interview with the facility Administrator, Employee E1, on Friday January 24, 2024, at approximately 1:00 p.m. confirmed this finding.	F 0600		

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F 0600  SS=D	Continued from page 18  28 Pa. Code 211.10(c)(d) Resident Care Policies  28 Pa. Code 211.12(d)(1)(5) Nursing Services	F 0600		
F 0625  SS=D	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr  §483.15(d) Notice of bed-hold policy and return-  §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.  §483.15(d)(2) Bed-hold notice upon transfer. At the time of	F 0625	1. Unable to retroactively resolve as R15 is already back into the center. R15 was educated of bed hold policy if for future he does require hospitalization. 2. Center unable to retroactively supply bed hold policies. 3. NHA/Designee will educate nursing supervisors on bed hold policies for facility-initiated transfers to the hospital. 4. NHA/Designee will conduct an audit on all facility-initiated transfers 3 times per week for 4 weeks then 1 time a month for 2 months. Audit findings will be addressed and submitted to the Quality Assurance Performance Improvement Committee for further review and recommendations as needed.	Completion Date: <b>03/05/2025</b> Status: <b>APPROVED</b> Date: <b>02/18/2025</b>

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F 0625  SS=D	Continued from page 19  transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.  This REQUIREMENT is not met as evidenced by:	F 0625		

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F 0625  SS=D	Continued from page 20  Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident and resident representative receive written notice of the facility bed-hold policy at the time of a facility-initiated transfer to a hospital for one of 3 residents reviewed for hospitalization. (Resident R15)  Findings include:  Review of nursing note for Resident R15, dated August 6, 2024, revealed that Resident R15 was admitted to the hospital for chest pain.  Further review of Resident R15's clinical record revealed that there was no documented evidence that the resident and his representative were provided with a written notice of the facility bed-hold policy at the time of Resident R15's facility-initiated transfer to the hospital.  Interview with the Nursing Home Administrator, Employee E1, on January 24, 2025 at 9:36 a.m.	F 0625		

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F 0625  SS=D	Continued from page 21  that Resident R15 and his representative were not provided with the bed hold policy, that included information explaining the duration of the bed-hold, bed hold reserve payment and permitting return to a bed at the facility. Further interview confirmed that there was no system in place to ensure that the resident and resident representative receive written notice of the facility bed-hold policy at the time of a facility-initiated transfer to a hospital.  28 Pa Code 201.14(a) Responsibility of licensee  28 PA Code 201.29(f) Resident rights	F 0625		
F 0655  SS=D		F 0655		

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F 0655  SS=D	Continued from page 22  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:	F 0655	1. R114 was given a shower at the time of request. R277 no longer resides in the center. 2. An initial audit was conducted of current residents to validate care plans are updated with bathing preferences and assistance needs. An initial audit was completed of residents that require enhanced barrier precautions to validate orders and care plans. Variances were addressed at the time of the audit and placed on the facility audit tool 3. DON/Designee educated the nursing staff on residents' bathing preferences and assistance needs and obtaining orders and updating care plans for enhanced barrier precautions. 4. DON/Designee will conduct a random audit to ensure shower preferences are being met and enhanced barrier precautions orders and care plans are updated. This audit will be conducted 3 times per week for 4 weeks then 1 time a month for 2 months. Audit findings will be addressed and submitted to the Quality Assurance Performance	Completion Date: <b>03/05/2025</b> Status: <b>APPROVED</b> Date: <b>02/18/2025</b>

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F 0655  SS=D	Continued from page 23  (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (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	Improvement Committee for further review and recommendations as needed.	

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F 0655  SS=D	Continued from page 24  Based on observations, review of facility policies, clinical record reviews and interviews with residents and staff, it was determined that the facility failed to develop baseline care plans related to bathing and enhanced barrier precautions for two of 30 residents reviewed (Residents R114 and R277).  Findings include:  Review of facility policy, "Activities of Daily Living (ADL), Supporting" dated March 2018, revealed, "Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care)."  Interview on January 21, 2025, at 11:13 a.m. Resident R114 stated that she wants to have a real shower, that she only gets provided with a basin of water to wash herself in bed and that she has not had her hair washed since her admission to the	F 0655		

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F 0655  SS=D	Continued from page 25  facility.  Review of Resident R114's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated December 22, 2024, revealed that the resident was admitted to the facility on December 16, 2024, and had diagnoses including orthopedic (branch of medicine that treats disorders related to bones, muscles and ligaments) aftercare and complication of internal orthopedic devices. Continued review revealed that the resident required substantial or maximal assistance (caregiver does more than half the effort) for bathing.  Review of Resident R114's care plan, dated initiated December 16, 2024, revealed that the resident had a left hip replacement and that the resident had an activities of daily living self-care performance deficit. Continued review revealed that there were no interventions related to the resident's preferences and assistance needs related to bathing.  Interview on January 23, 2025, at 12:26 p.m.	F 0655		

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F 0655  SS=D	<p>Continued from page 26</p> <p>Employee E7, nurse aide, was unable to state what level of assistance or preferences Resident R114 required for bathing.</p> <p>Review of facility policy, "Enhanced Barrier Precautions" dated March 2024, revealed, "Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the transmission of multi-drug resistant organisms (MDROs) to residents." Continued review revealed, "EBPs are indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. Wounds generally include chronic wounds (i.e., pressure ulcers, diabetic foot ulcers, venous stasis ulcers, and unhealed surgical wounds)."</p> <p>Interview on January 22, 2025, at 10:42 a.m. Resident R277 stated that has a surgical abdominal wound that has a lot of drainage and requires dressing changes twice per day.</p> <p>Review of Resident R277's Admission MDS, dated</p>	F 0655		

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F 0655  SS=D	<p>Continued from page 27</p> <p>January 13, 2025, revealed that the resident was admitted to the facility on January 7, 2025, and had diagnoses including orthopedic aftercare. Continued review revealed that the resident had a surgical wound.</p> <p>Review of Resident R277's care plan, dated initiated January 11, 2025, revealed that the resident had impaired skin integrity related to a surgical wound to her abdomen. Continued review revealed no indication that the resident required enhanced barrier precautions.</p> <p>Observation on January 24, 2025, at 12:10 p.m. revealed a sign was posted outside of Resident R277's door which indicated that the resident required enhanced barrier precautions. Interview, at the time of the observation, Employee E5, licensed nurse, confirmed that Resident R277 required enhanced barrier precautions due to her surgical wound. Employee E5, licensed nurse, also confirmed that there were no physician orders or care plan to indicate that the resident required</p>	F 0655		

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F 0655  SS=D	Continued from page 28  enhanced barrier precautions.  28 Pa Code 211.10(a) Resident care policies  28 Pa Code 211.10(c) Resident care policies	F 0655		
F 0676  SS=D		F 0676		

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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 0676  SS=D	Continued from page 29  483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities  §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:  §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...  §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:  §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,  §483.24(b)(2) Mobility-transfer and ambulation, including walking,  §483.24(b)(3) Elimination-toileting,	F 0676	1. R114 was given a shower at the time of request. Unable to retroactively resolve R78 not eating his full meal and no adverse effects were noted.  2. An initial audit was conducted to validate assistance is provided with bathing and 1:1 feeding assistance. Variances were addressed at the time of the audit and placed on the facility audit tool  3. DON/designee will re educate the nursing staff on providing bathing and 1:1 feeding assistance.  4. DON/Designee will conduct random audits to ensure bathing and 1:1 feeding assistance is being provided. This audit will be conducted 3 times per week for 4 weeks then 1 time a month for 2 months. Audit findings will be addressed and submitted to the Quality Assurance Performance Improvement Committee for further review and recommendations as needed.	Completion Date: <b>03/05/2025</b> Status: <b>APPROVED</b> Date: <b>02/18/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395722</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/27/2025</b>
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F 0676  SS=D	Continued from page 30  §483.24(b)(4) Dining-eating, including meals and snacks,  §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems.  This REQUIREMENT is not met as evidenced by:	F 0676		

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F 0676  SS=D	Continued from page 31  Based on observations, review of facility policies, clinical record reviews and interviews with residents and staff, it was determined that the facility failed to provide assistance with bathing and eating for two of 30 residents reviewed (Residents R114 and R78).  Findings include:  Review of facility policy, "Activities of Daily Living (ADL), Supporting" dated March 2018, revealed, "Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs)." Continued review revealed, "Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care) [and] dining (meals and snacks)."  Interview on January 21, 2025, at 11:13 a.m. Resident R114 stated that she wants to have a real	F 0676		

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F 0676  SS=D	Continued from page 32  shower, that she only gets provided with a basin of water to wash herself in bed and that she has not had her hair washed since her admission to the facility."  Review of Resident R114's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated December 22, 2024, revealed that the resident was admitted to the facility on December 16, 2024, and had diagnoses including orthopedic (branch of medicine that treats disorders related to bones, muscles and ligaments) aftercare and complication of internal orthopedic devices. Continued review revealed that the resident required substantial or maximal assistance (caregiver does more than half the effort) for bathing.  Review of Resident R114's care plan, dated initiated December 16, 2024, revealed that the resident had a left hip replacement and that the resident had an activities of daily living self-care performance deficit. Continued review revealed that there were no interventions related to the resident's preferences	F 0676		

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F 0676  SS=D	Continued from page 33  and assistance needs related to bathing.  Review of Resident R114's Kardex (summary of a resident's care needs) dated January 23, 2025, revealed that the resident had a bathing schedule of Wednesdays and Saturdays.  Review of nurse aide documentation for the past 30 days for Resident R114 revealed no indication that any showers or bathing was provided for the resident until January 22, 2025.  Review of treatment administration records for December 2024 and January 2025 for Resident R114 revealed that a bathing schedule was not ordered for the resident until January 22, 2025.  Interview on January 23, 2025, at 12:26 p.m. Employee E7, nurse aide, was unable to state what level of assistance or preferences Resident R114 required for bathing. Employee E7, nurse aide, stated that she sets Resident R114 up in bed with a basin of water, that she encourages the resident to	F 0676		

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F 0676  SS=D	Continued from page 34  wash herself and that she has not washed her hair because her family comes in and applies hair products. Employee E7, nurse aide, was unable to determine if the resident had her hair washed since her admission to the facility.  Review of Resident R78's Admission MDS, dated January 2, 2025, revealed that the resident was admitted to the facility on December 27, 2024, and had diagnoses including cerebrovascular accident (damage to the brain from interruption of its blood supply), aphasia (loss of ability to understand or express speech, caused by brain damage), hemiplegia (paralysis) and dysphagia (difficulty swallowing). Continued review revealed that the resident was dependent on staff for eating.  Review of progress notes for Resident R78 revealed a practitioner note, dated January 3, 2025, which indicated that the resident reported that he was unable to feed himself independently due to shoulder and hand fractures (broken bones). The practitioner ordered 1:1 feeding assistance with all meals.	F 0676		

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F 0676  SS=D	Continued from page 35  Review of physician orders for Resident R78 revealed an order, dated January 3, 2025, for 1:1 feeding assistance with all meals.  Review of Resident R78's care plan, dated initiated January 3, 2025, revealed that the resident required total assistance with eating and drinking.  Observation on January 21, 2025, at 12:41 p.m. revealed that lunch meals arrived on the first floor nursing unit and were distributed to residents.  Continued observation on January 21, 2025, at 1:36 p.m. revealed that Resident R78's lunch tray was on a table beside him and was untouched. Resident R78's stated that he was unable to reach his tray and that no one set up his lunch. Resident R78 requested assistance to eat his lunch. Employee E5, licensed nurse, was informed of Resident R78's request for assistance. Employee E5, licensed nurse, proceeded to enter the resident's room and set up his lunch tray in front of him. Employee E5, licensed	F 0676		

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F 0676  SS=D	Continued from page 36  nurse, then left the room without providing any 1:1 assistance to the resident.  Further observation on January 21, 2025, at 1:51 p.m. revealed that Resident R78 had only eaten a few bites of the chicken that was served for the meal. The rest of the food on his tray was untouched. Resident R78 stated that no one provided assistance to him with his meal, other than setting up his tray in front of him. Resident R78 demonstrated that he was unable to hold his fork and unable to feed himself. Resident R78 stated that the food was cold from sitting out so long that he no longer wanted to eat it. Observations throughout the lunch meal revealed that Resident R78 was not provided with 1:1 feeding assistance from staff.  Observation on January 22, 2025, at 12:20 p.m. revealed that Resident R78's lunch tray was setup in front of him. Resident R78 was trying to feed himself and had great difficulty picking up his fork. Observations throughout the lunch meal revealed that Resident R78 was not provided with 1:1	F 0676		

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F 0676  SS=D	Continued from page 37  feeding assistance from staff.  Interview on January 23, 2025, at 12:16 p.m. Employee E9, nurse aide, stated that she just found out yesterday that Resident R78 required 1:1 feeding assistance. Employee E9, nurse aide, stated that Resident R78 only ate a few bites of his lunch today because he did not like it. No alternate food items were offered to Resident R78.  28 Pa Code 211.10(a) Resident care policies  28 Pa Code 211.10(d) Resident care policies	F 0676		
F 0684  SS=D		F 0684		

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F 0684  SS=D	Continued from page 38  483.25 Quality of Care  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.  This REQUIREMENT is not met as evidenced by:	F 0684	1. Unable to retroactively correct R107, R277, R278 being administered medication late. 2. An initial was conducted of past 7 days to validate timely medication administration. Variances were addressed at the time of the audit and placed on the facility audit tool 3. DON/Designee will re-educate licensed nursing staff on timeliness of medication administration. 4. DON/Designee will conduct random audits to validate medications were administered timely. This audit will be conducted 3 times per week for 4 weeks then 1 time a month for 2 months. Audit findings will be addressed and submitted to the Quality Assurance Performance Improvement Committee for further review and recommendations as needed.	Completion Date: <b>03/05/2025</b> Status: <b>APPROVED</b> Date: <b>02/18/2025</b>

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F 0684  SS=D	Continued from page 39  Based on observations, review of facility policies, clinical record reviews and interviews with residents and staff, it was determined that the facility failed to administer medications in a timely manner for three of 30 residents reviewed (Residents R107, R277 and R278).  Findings include:  Review of facility policy, "Administering Medications" dated April 2019, revealed, "Medications are administered in a safe and timely manner." Continued review revealed, "Medications are administered within one (1) hour of their prescribed time."  Interview on January 21, 2025, at 1:16 p.m. Resident R107 stated that she did not receive her medications that were scheduled for 9:00 p.m. until after midnight last night. Resident R107 continued that medications are often administered late.  Review of Resident R107's Medication	F 0684		

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F 0684  SS=D	Continued from page 40  Administration Records (MAR) for January 2025 revealed that she was scheduled to receive the following medications at 9:00 p.m.: amitriptyline (treats depression), clobazam (prevents seizures), carbamazepine (prevents seizures), lacosamide (prevents seizures) and levetiracetam (prevents seizures).  Review of Resident R107's Medication Administration Audit Report revealed that Resident R107's medications that were scheduled for January 20, 2025, at 9:00 p.m. were not administered until January 21, 2025, at 12:20 a.m.  Continued review of Resident R107's Medication Administration Records (MAR) for January 2025 revealed that she was scheduled to receive the following medications at 9:00 a.m.: enoxaparin (prevents blood clots), iron (treats anemia), carbamazepine (prevents seizures), lacosamide (prevents seizures) and levetiracetam (prevents seizures).	F 0684		

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F 0684  SS=D	Continued from page 41  Continued review of Resident R107's Medication Administration Audit Report revealed that Resident R107's medications that were scheduled for January 21, 2025, at 9:00 a.m. were not administered until January 21, 2025, at 1:56 p.m.  Interview on January 21, 2025, at 1:28 p.m. Resident R277 stated that she receives her medications late.  Review of Resident R277's Medication Administration Records (MAR) for January 2025 revealed that she was scheduled to receive the following medications at 9:00 a.m.: duloxetine (treats depression), fluticasone (treats allergies), lidocaine patch (relieves pain), lisinopril-hydrochlorothiazide (treats high blood pressure), montelukast (treats allergies), apixaban (prevents blood clots) and baclofen (treats muscle spasms).  Review of Resident R277's Medication Administration Audit Report revealed that Resident R277's medications that were scheduled for January	F 0684		

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F 0684  SS=D	Continued from page 42  21, 2025, at 9:00 a.m. were not administered until January 21, 2025, at 1:51 p.m.  Interview on January 21, 2025, at 1:18 p.m. Resident R278 stated that she had not received any of her morning medications yet today.  Review of Resident R278's Medication Administration Records (MAR) for January 2025 revealed that she was scheduled to receive the following medications at 9:00 a.m.: furosemide (treats fluid retention), latanoprost (treats glaucoma), metoprolol (treats high blood pressure) and prednisone (steroid medication).  Review of Resident R278's Medication Administration Audit Report revealed that Resident R278's medications that were scheduled for January 21, 2025, at 9:00 a.m. were not administered until January 21, 2025, at 1:55 p.m.  Observation on January 21, 2025, at 11:30 a.m. revealed Employee E5, licensed nurse, administering	F 0684		

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F 0684  SS=D	Continued from page 43  morning medications to residents. Interview, at the time of the observation, Employee E5, licensed nurse, stated that she was running late and still administering morning medications.  28 Pa Code 211.12(d)(5) Nursing services	F 0684		
F 0694  SS=D		F 0694		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395722</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/27/2025</b>
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STATE LICENSE NUMBER: <b>180102</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 0694  SS=D	Continued from page 44  483.25(h) Parenteral/IV Fluids  § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.  This REQUIREMENT is not met as evidenced by:	F 0694	<ol style="list-style-type: none"> <li>R110's PICC dressing was changed immediately. No adverse effects were noted.</li> <li>An initial audit was conducted of residents to validate that their PICC dressings were changed per order. Variances were addressed at the time of the audit and placed on the facility audit tool.</li> <li>DON/Designee will re-educate the licensed nursing staff on changing PICC line dressings per order.</li> <li>DON/Designee will conduct random audits of residents with PICC lines to ensure dressing changes are completed per order. This audit will be conducted 3 times per week for 4 weeks then 1 time a month for 2 months. Audit findings will be addressed and submitted to the Quality Assurance Performance Improvement Committee for further review and recommendations as needed.</li> </ol>	Completion Date: <b>03/05/2025</b> Status: <b>APPROVED</b> Date: <b>02/18/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395722</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/27/2025</b>	
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F 0694  SS=D	Continued from page 45  Based on observation, interviews with resident and staff, review of clinical records and facility policy, it was determined that the facility failed to maintain a peripheral inserted central catheter (PICC) consistent with professional standards of practice and in accordance with physician orders and the comprehensive person-centered care plan, for one of 24 residents reviewed (Resident R110).  Findings include:  Review of the facility policy titled "Central Venous Catheter Care and Dressing Changes," revised on March 2022 states, " The purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressings. Perform site care immediately if the integrity of the dressing is compromised (e.g., damp, loosened or visibly soiled) and at least every 7 days.	F 0694		

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F 0694  SS=D	<p>Continued from page 46</p> <p>Resident R110 clinical records revealed the resident was admitted to the facility on December 5, 2025 diagnosed with osteomyelitis (bone infection) of the vertebra (spine) and received intravenous (IV) antibiotics through the resident's PICC line.</p> <p>Review of Resident R110's physician orders dated December 24, 2024, instructed to change the PICC dressing on admission, every seven days and as needed.</p> <p>On January 22, 2025, at approximately 11:30 a.m. surveyor observed Resident R110's PICC site on the resident's right upper arm. The dressing was dated January 11, 2024, and appeared soiled with edges of the dressing no longer adhering to the skin.</p> <p>Review of R110's treatment administration for the PICC dressing change documented last dressing change was done yesterday by Licensed Practical Nurse (LPN) Employee E11.</p> <p>Interview with the Assistant Director of Nursing</p>	F 0694		

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F 0694  SS=D	Continued from page 47  (ADON) Employee E14, on January 22, 2025 at 11:55 a.m. stated, "PICC dressing change may have a date of 2024 but even still it should have been changed since it looks like Jan 11th or people been signing it out (as completed) and not doing it."  During an interview with the ADON and LPN Employee E11 on January 22, 2025 at approximatley 12:00 p.m. the LPN confirmed, "I have never changed the resident's (R110) PICC line."  28 Pa. Code 211.10(c) Resident care policies  28 Pa. Code 211.12(d)(5) Nursing services	F 0694		
F 0755  SS=D		F 0755		

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F 0755  SS=D	Continued from page 48  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. Unable to retroactively correct. No adverse effects were noted. 2. An initial audit was conducted to validate shift to shift counts in narcotic log books are completed. Variances were addressed at the time of the audit and placed on the facility audit tool  3. DON/Designee will re-educate the licensed nursing staff on proper documentation of shift to shift counts in the narcotic log books. 4. DON/Designee will conduct random audits of narcotic log books to ensure documentation of shift to shift counts are completed. This audit will be conducted 3 times per week for 4 weeks then 1 time a month for 2 months. Audit findings will be addressed and submitted to the Quality Assurance Performance Improvement Committee for further review and recommendations as needed.	Completion Date: <b>03/05/2025</b> Status: <b>APPROVED</b> Date: <b>02/18/2025</b>

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F 0755  SS=D	Continued from page 49  This REQUIREMENT is not met as evidenced by:	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395722</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/27/2025</b>	
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F 0755  SS=D	Continued from page 50  Based on observations, review of facility policies and interviews with staff, it was determined that the facility failed to ensure that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled for three of three medication carts reviewed (first floor front, middle and back medication carts).  Findings include:  Review of facility policy, "Controlled Substances" dated November 2022, revealed, "Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up." Continued review revealed, "Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services."	F 0755		

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F 0755  SS=D	Continued from page 51  Observation on January 21, 2025, at 10:31 a.m. with Employee E10, licensed nurse, of the first floor front medication cart revealed that there was no documentation in the narcotic log book that shift-to-shift counts were completed at any time from October 15 to 22, 2024; October 24 to November 28, 2024; December 1 to 15, 2024; December 17 to 21, 2024; December 23 to 30, 2024; and January 1 to 7, 2025. Further, there were no entries in the log book after January 10, 2025.  Interview, at the time of the observation, Employee E10, licensed nurse, confirmed the above findings.  Observation on January 21, 2025, at 11:32 a.m. with Employee E11, licensed nurse, of the first floor back medication cart revealed that there was no documentation in the narcotic log book that shift-to-shift counts were completed on January 11, 2025. Further, there was no entry in the log book for January 21, 2025.	F 0755		

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F 0755  SS=D	Continued from page 52  Interview, at the time of the observation, Employee E11, licensed nurse, confirmed the above findings. Employee E11 then proceeded to sign the log book for January 21, 2025, however, there was no signature from the previous night shift nurse to indicate that the shift-to-shift count had been completed.  Observation on January 21, 2025, at 11:52 a.m. of the first floor middle medication cart with Employee E5, licensed nurse, revealed that there was no documentation in the narcotic log book that shift-to-shift counts were completed at any time from November 4 to 11, 2024; November 12 to 19, 2024; November 21 to 27, 2024; December 7 to 23, 2024; December 24, 2024 to January 5, 2025; and January 7, 2025. Further, there were no entries in the log book after January 8, 2025.  Interview, at the time of the observation, Employee E5, licensed nurse, confirmed the above findings.  28 Pa Code 211.9(a)(1) Pharmacy services	F 0755		

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F 0755  SS=D	Continued from page 53  28 Pa Code 211.9(k) Pharmacy services	F 0755		
F 0761  SS=D	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.	F 0761	1. R122, R25, R5, R380 open and undated medication were disposed of and replaced. 2. An initial audit was conducted of insulin pens to ensure they are properly labeled and dated. Variances were addressed at the time of the audit and placed on the facility audit tool. 3. DON/Designee will re-educate licensed nurses on proper labeling and dating insulin pens. 4. DON/Designee will conduct random audits on insulin pens being labeled and dated correctly. This audit will be conducted 3 times per week for 4 weeks then 1 time a month for 2 months. Audit findings will be addressed and submitted to the Quality Assurance Performance Improvement Committee for further review and recommendations as needed.	Completion Date: <b>03/05/2025</b> Status: <b>APPROVED</b> Date: <b>02/18/2025</b>

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F 0761  SS=D	Continued from page 54  This REQUIREMENT is not met as evidenced by:	F 0761		

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F 0761  SS=D	Continued from page 55  Based on observations, review of facility policies and interviews with staff, it was determined that the facility failed to ensure that insulin pens were labeled in accordance with currently accepted professional principles for two of three medication carts reviewed (first floor back and middle medication carts).  Findings include:  Review of facility policy, "Administering Medications" dated April 2019, revealed, "When opening a multi-dose container, the date opened is recorded on the container." Continued review revealed, "Insulin pens are clearly labeled with the resident's name or other identifying information."  Observation on January 21, 2025, at 11:32 a.m. of the first floor back medication cart with Employee E11, licensed nurse, revealed the following: An aspart (rapid acting) insulin (medication used to lower blood sugar levels) pen for Resident R122 that was opened and undated;	F 0761		

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F 0761  SS=D	Continued from page 56  A glargine (long acting) insulin pen for Resident R25 that was opened and undated; A lispro (rapid acting) insulin pen the was opened, undated and was not labeled with a resident's name; A degludec (long acting) insulin pen for Resident R5 that was opened and undated; and An aspart insulin pen for Resident R380 that was opened and undated.  Interview, at the time of the observation, Employee E11, licensed nurse, confirmed the above findings.  Observation on January 21, 2025, at 11:52 a.m. of the first floor middle medication cart with Employee E5, licensed nurse, revealed the following: A glargine insulin pen for Resident R277 that was opened and undated.  Interview, at the time of the observation, Employee E5, licensed nurse, confirmed the above findings.  28 Pa Code 211.9(a)(1) Pharmacy services	F 0761		

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F 0761  SS=D	Continued from page 57  28 Pa Code 211.12(d)(5) Nursing services	F 0761		
F 0806  SS=D	483.60(d)(4)(5) Resident Allergies, Preferences, Substitutes  §483.60(d) Food and drink Each resident receives and the facility provides-  §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences;  §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice;  This REQUIREMENT is not met as evidenced by:	F 0806	1. R40 preferences were updated, R278 no longer resides in the center. 2. An initial audit was conducted to validate residents meal preferences are provided. Variances were addressed at the time of the audit and placed on the facility audit tool 3. NHA/Designee to re-educate food service director and dietician on providing food preferences. 4. NHA/Designee will conduct random audits on food preference and tray accuracy 3 times per week for 4 weeks then 1 time a month for 2 months. Audit findings will be addressed and submitted to the Quality Assurance Performance Improvement Committee for further review and recommendations as needed.	Completion Date: <b>03/05/2025</b> Status: <b>APPROVED</b> Date: <b>02/18/2025</b>

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F 0806  SS=D	Continued from page 58  Based on observations, clinical record reviews and interviews with residents and staff, it was determined that the facility failed to provide foods in accordance with residents' preferences for two of 30 residents reviewed (Residents R278 and R40).  Findings include:  Review of Resident R40's clinical record revealed that the resident was alert and oriented. The resident was provided a regular textured diet with fortified meals three times a day.  Interview with Resident R40 on January 21, 2025, at 12:00 p.m. indicated he does not receive the correct food at meal time as follows: Requested for lunch on January 21, 2025, tuna salad received chicken Requested for lunch on January 22, 2025. coffee but received a tea bag, with no hot water nor cream. Request for lunch on January 23, 2025, kielbasa and received chicken.	F 0806		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395722</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/27/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>UNIVERSITY CITY REHABILITATION AND HEALTHCARE CENTER</b>  STATE LICENSE NUMBER: <b>180102</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>3609 CHESTNUT STREET PHILADELPHIA, PA 19104</b>		
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F 0806  SS=D	Continued from page 59  Interview on January 21, 2025, at 1:19 p.m. Resident R278 stated that she eats a vegetarian diet and that she had not been getting vegetarian protein options with her meals.  Observation, at the time of the interview, Resident R278's lunch tray consisted of potatoes, corn, carrots, pie, and a juice cup. Resident R278 stated that she requested a veggie burger with her meal and was told that it was not available from the kitchen.  Review of Resident R278's meal slip indicated that she eats a vegetarian diet and does not eat dairy products; Resident R278 stated that she has not been provided with soy milk as requested. Resident R278 provided her meal slip from breakfast; the meal slip indicated that the resident was supposed to receive waffles, hot cereal and a vegetarian breakfast meat product. Resident R278 stated that she did not receive the vegetarian breakfast meat nor any other source of protein with her breakfast	F 0806		

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F 0806  SS=D	Continued from page 60  meal. Resident R278 stated that she wants to speak to the dietician about receiving a nutritional supplement since her nutritional needs for protein are not being met.  Review of Resident R278's care plan, dated initiated January 6, 2025, revealed that the resident was admitted to the facility on January 5, 2025, and that she followed a vegetarian diet.  Interview on January 23, 2025, at 2:40 p.m. Employee E12, Food Service Director, stated that the only vegetarian food options that she has for residents are veggie burger patties and soy milk. Employee E12, stated that the facility was out of veggie burger patties and that there has never been any vegetarian breakfast meat products at the facility. Employee E12, stated that the facility has a case of soy milk and was unable to explain why Resident R278 was not provided with soy milk or any other alternative vegetarian sources of protein.  Interview on January 23, 2025, at 3:30 p.m.	F 0806		

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F 0806  SS=D	Continued from page 61  Employee E13, dietician, stated that she does not know why the facility has not been ordering vegetarian food products to meet Resident R278's and other vegetarian residents' nutritional needs. Employee E13, dietician, stated that she bought Resident R278 a rice and beans meal a few days ago because the facility did not have any vegetarian products available.  28 Pa. Code 201.18(b)(3) Management  28 Pa Code 211.6(a) Dietary services	F 0806		
F 0880  SS=D		F 0880		

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F 0880  SS=D	Continued from page 62  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	1. R105 no longer resides in the center. No adverse effects were noted. 2. An initial audit was conducted to validate EBP's are utilized during medication administration via feeding tube. Variances were addressed at the time of the audit and placed on the facility audit tool.  3. DON/Designee will re-educate all licensed nurses on utilizing EBP's during medication administration via feeding tube. 4. DON/Designee will conduct random audits to validate EBP's are utilized during medication administration via feeding tube 3 times per week for 4 weeks then 1 time a month for 2 months. Audit findings will be addressed and submitted to the Quality Assurance Performance Improvement Committee for further review and recommendations as needed.	Completion Date: <b>03/05/2025</b> Status: <b>APPROVED</b> Date: <b>02/18/2025</b>

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F 0880  SS=D	Continued from page 63  (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 64	F 0880		

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F 0880  SS=D	Continued from page 65  Based on observations, interviews with staff, review of clinical records and facility policy, it was determined the facility failed to utilize enhanced barrier precautions during medication administration for one of three reviewed residents with feeding tubes (Resident R105).  Findings included:  Review of the facility policy for Enhanced Barrier Precautions revised March 2024 states, "Enhanced barrier precautions (EBP's) are utilized to reduce the transmission of multi-drug-resistant organisms (MDROs) to residents. Policy Interpretation and Implementation revealed examples of high-contact resident care activities requiring the use of gown and gloves for EBP's include device care or use.  Review of Resident R105's clinical record revealed that ther esident was admitted to the facility with Oropharyngeal dysphagia (difficulty swallowing) malnutrition (lack in proper nutrition) and required a gastrostomy tube ( a surgical feeding tube inserted in	F 0880		

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F 0880  SS=D	Continued from page 66  the stomach through the abdomen. that allows delivery of nutrition, fluids, and medications).  Review of Resident R105's care plan for the feeding tube required that gloves and gown must be used during high-contact care activities including device care or use.  During observation of medication administration with Licensed Practical Nurse (LPN) Employee E15 on January 24, 2025 at 10:20 a.m. revealed the nurse did not don a gown and gloves while providing care to the resident's peg tube.  28 Pa. Code 211.10(c) Resident care policies  28 Pa. Code: 211.10(c)(d) Resident care policies.	F 0880		
F 0919  SS=D		F 0919		

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F 0919  SS=D	Continued from page 67  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	<ol style="list-style-type: none"> <li>1. R55 and R78 call bell has been replaced, is currently working properly and accessible. No adverse effects were noted.</li> <li>2. An initial audit was conducted to validate call bells were in proper working condition and accessible. Variances were addressed at the time of the audit and placed on the facility audit tool.</li> <li>3. NHA/Designee will re-educate all dept managers on validating call bells are properly working and accessible.</li> <li>4. NHA/Designee will conduct random audits on call bell functionality and accessibility 3 times per week for 4 weeks then 1 time a month for 2 months. Audit findings will be addressed and submitted to the Quality Assurance Performance Improvement Committee for further review and recommendations as needed.</li> </ol>	Completion Date: <b>03/05/2025</b> Status: <b>APPROVED</b> Date: <b>02/18/2025</b>

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F 0919  SS=D	Continued from page 68  Based on observations and interviews with residents and staff, it was determined that the facility failed to ensure that call devices were functional and accessible to residents for two of 30 residents reviewed (Residents R55 and R78).  Findings include:  Interview on January 21, 2025, at 1:42 p.m. Resident R55 stated that his callbell did not work. Observation, at the time of the interview, confirmed that the callbell was non-functional.  Observation and interview on January 21, 2025, at 2:39 p.m. with the Nursing Home Administrator, confirmed that Resident R55's callbell did not work.  Observation on January 22, 2025, at 9:30 a.m. revealed that Resident R78's callbell was on the floor. Resident R78 stated that he was unable to reach the callbell and had no other way to call for assistance. Resident R78 was soft-spoken and unable to yell or call out in a tone loud enough to be	F 0919		

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F 0919  SS=D	Continued from page 69  heard outside of his room.  Observation on January 23, 2025, at 9:17 a.m. revealed that Resident R78's callbell was on the floor and out of the resident's reach.  Interview on January 23, 2025, at 12:16 p.m. Employee E9, nurse aide, stated that sometimes Resident R78's callbell falls on the floor.  28 Pa Code 205.67(j)(k) Electric requirements for existing construction	F 0919		

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P 5520	<p>Nursing services.</p> <p>(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.</p> <p>This REGULATION is not met as evidenced by:</p>	P 5520	<p>No specific residents were identified. No residents were negatively impacted by the CNA ratios. – An audit was completed of staffing ratios for the past 30 days. Variances were reviewed with the staffing coordinator and recorded on the facility audit tool.</p> <p>The Administrator re-educated the staffing coordinator on the staffing ratios. The Administrator has reviewed staff recruitment and retention initiatives and have communicated those initiatives to the facility recruitment manager. The Administrator / Designee will audit CNA ratios 3 times per week for 4 weeks then weekly for 2 months. Audit findings will be submitted to the Quality Assurance Performance Improvement Committee monthly for further review and recommendations as needed. Further audit frequency will be determined based on the outcome of the previously completed audit findings.</p>	<p>Completion Date: <b>03/05/2025</b></p> <p>Status: <b>APPROVED</b></p> <p>Date: <b>02/18/2025</b></p>
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE:		(X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395722</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/27/2025</b>
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P 5520	Continued from page 1  Based on review of nursing staff schedules, punch reports and interviews with staff, it was determined that the facility failed to maintain required staffing ratios, including one nurse aide per 10 residents during the day shift, one nurse aide per 11 residents during the evening shift and one nurse aide per 15 residents during the overnight shift, on 15 of 21 days reviewed (July 14, 15, 16, 17, 18 and 20, 2024; September 3, 4 and 7, 2024; January 17, 18, 19, 20, 21 and 22, 2025).  Findings include:  Review of facility census data revealed that on July 14, 2024, the facility census was 114, which required 77.73 hours of nurse aides during the evening shift. Review of the nursing time schedules and punch reports revealed 66.00 hours of nurse aide care was provided during the shift.  Review of facility census data revealed that on July 14, 2024, the facility census was 114, which required 57.00 hours of nurse aides during the	P 5520		

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P 5520	<p>Continued from page 2</p> <p>overnight shift. Review of the nursing time schedules and punch reports revealed 54.50 hours of nurse aide care was provided during the shift.</p> <p>Review of facility census data revealed that on July 15, 2024, the facility census was 115, which required 78.41 hours of nurse aides during the evening shift. Review of the nursing time schedules and punch reports revealed 52.50 hours of nurse aide care was provided during the shift.</p> <p>Review of facility census data revealed that on July 16, 2024, the facility census was 115, which required 78.41 hours of nurse aides during the evening shift. Review of the nursing time schedules and punch reports revealed 75.00 hours of nurse aide care was provided during the shift.</p> <p>Review of facility census data revealed that on July 17, 2024, the facility census was 119, which required 81.14 hours of nurse aides during the evening shift. Review of the nursing time schedules and punch reports revealed 67.50 hours of nurse</p>	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395722</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/27/2025</b>	
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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
P 5520	<p>Continued from page 3</p> <p>aide care was provided during the shift.</p> <p>Review of facility census data revealed that on July 18, 2024, the facility census was 119, which required 81.14 hours of nurse aides during the evening shift. Review of the nursing time schedules and punch reports revealed 60.00 hours of nurse aide care was provided during the shift.</p> <p>Review of facility census data revealed that on July 18, 2024, the facility census was 119, which required 59.50 hours of nurse aides during the overnight shift. Review of the nursing time schedules and punch reports revealed 52.50 hours of nurse aide care was provided during the shift.</p> <p>Review of facility census data revealed that on July 20, 2024, the facility census was 123, which required 61.50 hours of nurse aides during the overnight shift. Review of the nursing time schedules and punch reports revealed 37.50 hours of nurse aide care was provided during the shift.</p>	P 5520		

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P 5520	Continued from page 4  Review of facility census data revealed that on September 3, 2024, the facility census was 115, which required 78.41 hours of nurse aides during the evening shift. Review of the nursing time schedules and punch reports revealed 75.00 hours of nurse aide care was provided during the shift.  Review of facility census data revealed that on September 3, 2024, the facility census was 115, which required 57.50 hours of nurse aides during the overnight shift. Review of the nursing time schedules and punch reports revealed 52.50 hours of nurse aide care was provided during the shift.  Review of facility census data revealed that on September 4, 2024, the facility census was 117, which required 58.50 hours of nurse aides during the overnight shift. Review of the nursing time schedules and punch reports revealed 44.25 hours of nurse aide care was provided during the shift.  Review of facility census data revealed that on September 7, 2024, the facility census was 116,	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395722</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/27/2025</b>
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P 5520	Continued from page 5  which required 58.00 hours of nurse aides during the overnight shift. Review of the nursing time schedules and punch reports revealed 52.50 hours of nurse aide care was provided during the shift.  Review of facility census data revealed that on January 17, 2025, the facility census was 120, which required 60.00 hours of nurse aides during the overnight shift. Review of the nursing time schedules and punch reports revealed 30.00 hours of nurse aide care was provided during the shift.  Review of facility census data revealed that on January 18, 2025, the facility census was 119, which required 59.50 hours of nurse aides during the overnight shift. Review of the nursing time schedules and punch reports revealed 45.00 hours of nurse aide care was provided during the shift.  Review of facility census data revealed that on January 19, 2025, the facility census was 119, which required 59.50 hours of nurse aides during the overnight shift. Review of the nursing time	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395722</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/27/2025</b>
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P 5520	Continued from page 6  schedules and punch reports revealed 37.50 hours of nurse aide care was provided during the shift.  Review of facility census data revealed that on January 20, 2025, the facility census was 117, which required 87.75 hours of nurse aides during the day shift. Review of the nursing time schedules and punch reports revealed 75.00 hours of nurse aide care was provided during the shift.  Review of facility census data revealed that on January 20, 2025, the facility census was 117, which required 79.77 hours of nurse aides during the evening shift. Review of the nursing time schedules and punch reports revealed 71.25 hours of nurse aide care was provided during the shift.  Review of facility census data revealed that on January 21, 2025, the facility census was 113, which required 84.75 hours of nurse aides during the day shift. Review of the nursing time schedules and punch reports revealed 72.00 hours of nurse aide care was provided during the shift.	P 5520		

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P 5520	Continued from page 7  Review of facility census data revealed that on January 21, 2025, the facility census was 113, which required 56.50 hours of nurse aides during the overnight shift. Review of the nursing time schedules and punch reports revealed 45.00 hours of nurse aide care was provided during the shift.  Review of facility census data revealed that on January 22, 2025, the facility census was 113, which required 77.05 hours of nurse aides during the evening shift. Review of the nursing time schedules and punch reports revealed 60.00 hours of nurse aide care was provided during the shift.  Review of facility census data revealed that on January 22, 2025, the facility census was 113, which required 56.50 hours of nurse aides during the overnight shift. Review of the nursing time schedules and punch reports revealed 52.50 hours of nurse aide care was provided during the shift.  Staffing calculations, nursing staff schedules and staff	P 5520		

Pennsylvania Department of Health

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P 5520	Continued from page 8  punch reports were reviewed with the Nursing Home Administrator on January 24, 2025, at 10:30 a.m. The Nursing Home Administrator confirmed that the required staffing ratios for nurse aides were not met on the above dates.	P 5520		
P 5530		P 5530		

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P 5530	Continued from page 9  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	No specific residents were identified. No residents were negatively impacted by the LPN ratios. – An audit was completed of staffing ratios for the past 30 days. Variances were reviewed with the staffing coordinator and recorded on the facility audit tool. The Administrator re-educated the staffing coordinator on the staffing ratios. The Administrator has reviewed staff recruitment and retention initiatives and have communicated those initiatives to the facility recruitment manager. The Administrator / Designee will audit LPN ratios 3 times per week for 4 weeks then weekly for 2 months. Audit findings will be submitted to the Quality Assurance Performance Improvement Committee monthly for further review and recommendations as needed. Further audit frequency will be determined based on the outcome of the previously completed audit findings.	Completion Date: <b>03/05/2025</b> Status: <b>APPROVED</b> Date: <b>02/18/2025</b>

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P 5530	Continued from page 10  Based on review of nursing staff schedules, punch reports and interviews with staff, it was determined that the facility failed to maintain required staffing ratios, including one LPN (Licensed Practical Nurse) per 25 residents during the day shift, one LPN per 30 residents during the evening shift, and one LPN per 40 residents during the overnight shift, on six of 21 days reviewed (July 16, 17 and 20, 2024; September 7, 2024; January 17 and 23, 2025).  Findings include:  Review of facility census data revealed that on July 16, 2024, the facility census was 115, which required 23.00 hours of LPNs during the overnight shift. Review of the nursing time schedules and punch reports revealed 16.00 hours of LPN care was provided during the shift.  Review of facility census data revealed that on July 17, 2024, the facility census was 119, which required 23.80 hours of LPNs during the overnight	P 5530		

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P 5530	Continued from page 11  shift. Review of the nursing time schedules and punch reports revealed 16.00 hours of LPN care was provided during the shift.  Review of facility census data revealed that on July 20, 2024, the facility census was 123, which required 39.36 hours of LPNs during the day shift. Review of the nursing time schedules and punch reports revealed 32.00 hours of LPN care was provided during the shift.  Review of facility census data revealed that on July 20, 2024, the facility census was 123, which required 32.80 hours of LPNs during the evening shift. Review of the nursing time schedules and punch reports revealed 28.00 hours of LPN care was provided during the shift.  Review of facility census data revealed that on September 7, 2024, the facility census was 116, which required 30.93 hours of LPNs during the evening shift. Review of the nursing time schedules and punch reports revealed 28.00 hours of LPN	P 5530		

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P 5530	<p>Continued from page 12</p> <p>care was provided during the shift.</p> <p>Review of facility census data revealed that on January 17, 2025, the facility census was 120, which required 24.00 hours of LPNs during the overnight shift. Review of the nursing time schedules and punch reports revealed 8.00 hours of LPN care was provided during the shift.</p> <p>Review of facility census data revealed that on January 23, 2025, the facility census was 112, which required 29.87 hours of LPNs during the evening shift. Review of the nursing time schedules and punch reports revealed 29.00 hours of LPN care was provided during the shift.</p> <p>Staffing calculations, nursing staff schedules and staff punch reports were reviewed with the Nursing Home Administrator on January 24, 2025, at 10:30 a.m. The Nursing Home Administrator confirmed that the required staffing ratios for LPNs were not met on the above dates.</p>	P 5530		

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P 5640	<p>Nursing services.</p> <p>(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.</p> <p>This REGULATION is not met as evidenced by:</p>	P 5640	<p>No residents were negatively impacted by not meeting 3.20 PPD. – The facility completed an audit of HPPD for the past 30 days. Variances were reviewed with the staffing coordinator and recorded on the facility audit tool. The Administrator re-educated the staffing coordinator on the required HPPD. The Administrator has reviewed staff recruitment and retention initiatives and have communicated those initiatives to the facility recruitment manager. The Administrator / Designee will audit centers HPPD 3 times per week for 4 weeks then weekly for 2 months. Audit findings will be submitted to the Quality Assurance Performance Improvement Committee monthly for further review and recommendations as needed. Further audit frequency will be determined based on the outcome of the previously completed audit findings</p>	<p>Completion Date: <b>03/05/2025</b> Status: <b>APPROVED</b> Date: <b>02/18/2025</b></p>

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P 5640	Continued from page 14  Based on review of nursing time schedules, punch reports and staff interviews, it was determined that the facility failed to provide a minimum of 3.20 hours of direct nursing care per resident on 16 of 21 days reviewed (July 14, 15, 16, 17, 18 and 20, 2024; September 3, 4 and 7, 2025; January 17, 18, 19, 20, 21, 22 and 23, 2025).  Findings include:  Review of facility census data, punch reports and nursing time schedules revealed that on July 14, 2024, the facility census was 114, and a total of 342.00 direct nursing staff hours were provided, which equaled 3.00 hours of direct nursing care per resident.  Review of facility census data, punch reports and nursing time schedules revealed that on July 15, 2024, the facility census was 115, and a total of 335.00 direct nursing staff hours were provided, which equaled 2.91 hours of direct nursing care per resident.	P 5640		

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P 5640	Continued from page 15  Review of facility census data, punch reports and nursing time schedules revealed that on July 16, 2024, the facility census was 115, and a total of 352.50 direct nursing staff hours were provided, which equaled 3.07 hours of direct nursing care per resident.  Review of facility census data, punch reports and nursing time schedules revealed that on July 17, 2024, the facility census was 119, and a total of 361.00 direct nursing staff hours were provided, which equaled 3.03 hours of direct nursing care per resident.  Review of facility census data, punch reports and nursing time schedules revealed that on July 18, 2024, the facility census was 119, and a total of 345.50 direct nursing staff hours were provided, which equaled 2.90 hours of direct nursing care per resident.  Review of facility census data, punch reports and	P 5640		

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P 5640	Continued from page 16  nursing time schedules revealed that on July 20, 2024, the facility census was 123, and a total of 329.00 direct nursing staff hours were provided, which equaled 2.67 hours of direct nursing care per resident.  Review of facility census data, punch reports and nursing time schedules revealed that on September 3, 2024, the facility census was 115, and a total of 353.00 direct nursing staff hours were provided, which equaled 3.07 hours of direct nursing care per resident.  Review of facility census data, punch reports and nursing time schedules revealed that on September 4, 2024, the facility census was 117, and a total of 359.25 direct nursing staff hours were provided, which equaled 3.07 hours of direct nursing care per resident.  Review of facility census data, punch reports and nursing time schedules revealed that on September 7, 2024, the facility census was 116, and a total of	P 5640		

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P 5640	Continued from page 17  347.75 direct nursing staff hours were provided, which equaled 3.00 hours of direct nursing care per resident.  Review of facility census data, punch reports and nursing time schedules revealed that on January 17, 2025, the facility census was 120, and a total of 337.50 direct nursing staff hours were provided, which equaled 2.81 hours of direct nursing care per resident.  Review of facility census data, punch reports and nursing time schedules revealed that on January 18, 2025, the facility census was 119, and a total of 363.00 direct nursing staff hours were provided, which equaled 3.05 hours of direct nursing care per resident.  Review of facility census data, punch reports and nursing time schedules revealed that on January 19, 2025, the facility census was 119, and a total of 346.00 direct nursing staff hours were provided, which equaled 2.91 hours of direct nursing care per	P 5640		

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NAME OF PROVIDER OR SUPPLIER: <b>UNIVERSITY CITY REHABILITATION AND HEALTHCARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>3609 CHESTNUT STREET PHILADELPHIA, PA 19104</b>		
STATE LICENSE NUMBER: <b>180102</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
P 5640	Continued from page 18  resident.  Review of facility census data, punch reports and nursing time schedules revealed that on January 20, 2025, the facility census was 117, and a total of 340.90 direct nursing staff hours were provided, which equaled 2.91 hours of direct nursing care per resident.  Review of facility census data, punch reports and nursing time schedules revealed that on January 21, 2025, the facility census was 113, and a total of 343.50 direct nursing staff hours were provided, which equaled 3.04 hours of direct nursing care per resident.  Review of facility census data, punch reports and nursing time schedules revealed that on January 22, 2025, the facility census was 113, and a total of 361.50 direct nursing staff hours were provided, which equaled 3.199 hours of direct nursing care per resident.	P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395722</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/27/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>UNIVERSITY CITY REHABILITATION AND HEALTHCARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>3609 CHESTNUT STREET PHILADELPHIA, PA 19104</b>		
STATE LICENSE NUMBER: <b>180102</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
P 5640	Continued from page 19  Review of facility census data, punch reports and nursing time schedules revealed that on January 23, 2025, the facility census was 112, and a total of 342.50 direct nursing staff hours were provided, which equaled 3.06 hours of direct nursing care per resident.  Staffing calculations, nursing staff schedules and staff punch reports were reviewed with the Nursing Home Administrator on January 24, 2025, at 10:30 a.m. The Nursing Home Administrator confirmed the required staffing minimum of 3.20 hours of direct nursing care per resident was not met on the above dates.	P 5640		



# Certified End Page

**UNIVERSITY CITY REHABILITATION AND HEALTHCARE CENTER**

**STATE LICENSE NUMBER: 180102**

**SURVEY EXIT DATE: 01/27/2025**

**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