STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395821	A. BLDG: 00 B. WING:	01/09/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
LITTLE FLOWER MANOR STATE LICENSE NUMBER: **121902**	**1201 SPRINGFIELD ROAD** **DARBY, PA 19023**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification Survey, Civil Rights Compliance Survey, and a State Licensure Survey, completed on December 9, 2025, it was determined that Little Flower Manor, 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 0000		
F 0656 SS=D		F 0656		

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 0656 SS=D	Continued from page 1 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	The Care Plan for Resident R70 was immediately updated on 01/09/2025 to reflect Resident R70's refusals of medications, PT, OT and Activities of Daily Living. Following the completion of the survey, the care plans for all the current residents were reviewed. Any resident that was refusing medications, treatments, therapies, ADLs, etc, had their care plans updated to reflect these refusals. Upon admission to the facility, refusals of care will be monitored by the Interdisciplinary Team (which would include our nursing, therapy, social service, activities and dietary team members). The care plans for these residents will reflect any refusals of medications, treatments, therapies, ADLs, etc. The RNAC will be responsible for monitoring the completion of these care plans and review them prior to each resident assessment and care conference.	Completion Date: **02/01/2025** Status: **APPROVED** Date: **01/30/2025**

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F 0656 SS=D	Continued from page 2 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656		

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F 0656 SS=D	Continued from page 3 Based on review of clinical records, facility policy, and staff interviews, it was determined that the facility failed to develop a person-centered comprehensive care plan for one of 18 residents reviewed (Resident R70). Findings include: A review of the facility policy "Care Plan", revised May 2023, revealed the facility will develop and implement a comprehensive person-centered care plan for each resident. The care plan will include measurable objectives and time frames to meet a resident's medical, nursing, and psychosocial needs that are identified in the comprehensive assessment. The care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. Clinical record review revealed Resident R70 was admitted to the facility on December 5, 2023, with diagnoses of Rhabdomyolysis (serious condition	F 0656		

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F 0656 SS=D	Continued from page 4 where your muscles break down and release toxins into your blood and kidneys), Hypertension (high blood pressure), and Malignant neoplasm of prostate (prostate cancer). Review of Resident R70's nursing notes from October 1, 2024 to January 8, 2024 revealed Resident R70 has been refusing various treatments several times weekly, such as Activities of Daily Living, medication, physical therapy, and occupational therapy. Review of Resident R70's care plan revealed no care plan related to Resident R70's refusal to treatments. Interview conducted on January 09, 2025 at 9:40 a.m. with Licensed nurse, Employee E3, confirmed Resident R70 did not have a care plan in place relating to the resident refusals to treatments. 28 Pa. Code: 211.12 (d) (1) (5) Nursing services.	F 0656		

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F 0656 SS=D	Continued from page 5 28 Pa. Code 211.10 (c) Resident care policies.	F 0656		
F 0757 SS=D	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by:	F 0757	On January 9, 2025, Loratadine was discontinued from the profile of Resident R30 as recommended by the Consultant Pharmacist. Going forward, all Pharmacy Consultant reports will now require a review by our Resident Care Coordinators after being scanned into the EMR system to ensure that all recommendations were addressed by the physician and that all orders were followed accordingly. The Director of QI will review the Pharmacy Consultant reports monthly for 6 months to ensure accuracy and then quarterly for 3 months. The Pharmacy Consultant will also inform the Director of Nursing each month that all recommendations from the previous month were addressed appropriately.	Completion Date: **02/01/2025** Status: **APPROVED** Date: **01/30/2025**

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F 0757 SS=D	Continued from page 6	F 0757		

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F 0757 SS=D	Continued from page 7 Based on review of clinical records and staff interview, it was determined that the facility failed to ensure that a resident's drug regimen was free of unnecessary drugs for one of 18 residents reviewed (Resident R30). Findings included: Review of facility policy tilted "Medication Regiment Review", revised June 2024, revealed if an irregularity is not time-sensitive but should be addressed before the consultant pharmacists' next monthly MRR, the facility staff and the consultant pharmacist will confer on the timeliness of attending physician/prescriber responses to identified irregularities based on the specific resident's clinical condition. Further review of facility policy revealed the physician/ prescriber should address the consultant pharmacist's recommendation no later than their next scheduled visit to the facility to assess the resident per policy, or applicable state and federal	F 0757		

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F 0757 SS=D	Continued from page 8 regulations. Clinical record review revealed Resident R30 was admitted to the facility on February 13, 2024 with a diagnosis that included Anxiety, Hypertension (high blood pressure), and acute respiratory failure. Review of Resident R30's monthly pharmacy review dated October 29, 2024 revealed Resident R30 received a nonsedating antihistamine, Loratadine 10 milligrams (mg) daily for seasonal allergic rhinitis. Pharmacist comments revealed administration should be limited to the allergy season to avoid adverse events attributed to daily long-term use. Pharmacist recommended physician to reevaluate the continued need for Loratadine perhaps a trail discontinuation/PRN (as needed) period. Further review of Resident R30's monthly pharmacy review revealed the physician agreed and accepted the recommendation on October 31, 2024. Review of Resident R30's clinical record revealed	F 0757		

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F 0757 SS=D	Continued from page 9 Resident R30 had a standing order for Loratadine 10 mg started on February 13, 2024. The order continued to be a standing order and did not have a stop date that was recommended by pharmacist on October 29, 2024. Interview conducted on January 08, 2024 with Employee E2, Director of Nursing, confirmed Resident R30 continued to have a standing order for Loratadine 10 mg and should have been discontinued per pharmacy recommendation and physician response. 28 Pa. Code 211.2 (d)(3) Medical Director 28 Pa. Code 211.9 (k) Pharmacy Services	F 0757		

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P 5530	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	Our Staffing Coordinator in conjunction with our Director of Nursing will monitor our daily census and prepare for any increase in census throughout the day. They will continue to use the staffing tool provided by DOH to ensure compliance with all PPDs and staffing ratios. This tool will be monitored by the Director of Nursing on a daily basis.	Completion Date: **02/01/2025** Status: **APPROVED** Date: **01/31/2025**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

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P 5530	Continued from page 1 Based on review of nursing schedules and staff interview, it was determined that the facility administrative staff did not ensure to provide a minimum of one LPN (licensed practical nurse) per 40 residents during night shift for four of 21 days reviewed (11/23/24, 11/24/24, 11/28/24, 11/29/24) Findings include: Review of facility census data indicated that on 11/23/2024, the facility census was 92, which required 2.30 LPN's during night shift. Review of nursing time schedules revealed 2.06 LPN's provided care on the night shift on 11/23/2024. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data indicated that on 11/24/2024, the facility census was 92, which required 2.30 LPN's during night shift.	P 5530		

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P 5530	Continued from page 2 Review of nursing time schedules revealed 2.14 LPN's provided care on the night shift on 11/24/2024. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data indicated that on 11/28/2024, the facility census was 92, which required 2.30 LPN's during night shift. Review of nursing time schedules revealed 2.23 LPN's provided care on the night shift on 11/28/2024. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data indicated that on 11/29/2024, the facility census was 92, which required 2.30 LPN's during night shift. Review of nursing time schedules revealed 1.45 LPN's provided care on the night shift on 11/29/2024. No additional excess higher-level staff were available to compensate this deficiency.	P 5530		

Certified End Page

LITTLE FLOWER MANOR

STATE LICENSE NUMBER: 121902

SURVEY EXIT DATE: 01/09/2025

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