| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
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| | 396076 | A. BLDG: 00<br>B. WING: | 01/13/2025 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
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| **MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK**<br>STATE LICENSE NUMBER: **041402** | **4001 FORD ROAD PHILADELPHIA, PA 19131** |

| (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 |
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| F 0000 | INITIAL COMMENT<br><br>Based on a Medicare/Medicaid Recertification Survey, Civil Rights Compliance Survey, State Licensure Survey, and an Abbreviated survey in response to three complaints, completed on January 13, 2025, it was determined that Monumental Post Acute Care at Woodside Park, 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 0623<br><br>SS=D | | F 0623 | | |

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 0623<br><br>SS=D | Continued from page 1<br><br>483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c) | F 0623 | State Long Term Care Ombudsmen have been notified of Transfers/discharge for R136<br><br>The Social Services team have been educated on the importance of adherence to regulations re: F623<br><br>All discharges transfers and discharges have been reviewed for the past three months. There were no further discrepancies in notification.<br><br>State Long Term Care Ombudsmen will be notified of emergency transfers in writing by Social Services or designee monthly.<br><br>Notification of State Long Term Care Ombudsmen will be reviewed/audited monthly for accuracy by Social Services and the results will be reported in monthly QAPI. | Completion Date: **02/21/2025**<br>Status: **APPROVED**<br>Date: **01/28/2025** |

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| F 0623<br><br>SS=D | Continued from page 2<br><br>(1)(i)(B) of this section;<br>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or<br>(E) A resident has not resided in the facility for 30 days.<br><br>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:<br>(i) The reason for transfer or discharge;<br>(ii) The effective date of transfer or discharge;<br>(iii) The location to which the resident is transferred or discharged;<br>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;<br>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;<br>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and | F 0623 | | |

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| F 0623<br><br>SS=D | Continued from page 3<br><br>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.<br><br>§483.15(c)(6) Changes to the notice.<br>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.<br><br>§483.15(c)(8) Notice in advance of facility closure<br>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).<br><br>This REQUIREMENT is not met as evidenced by: | F 0623 | | |

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| F 0623<br><br>SS=D | Continued from page 4<br><br>Based on review of facility documentation, review of clinical records, and interviews with staff, it was determined that the facility failed to notify the Office of the State Long-Term Care Ombudsman of facility-initiated emergency transfers to the hospital and that a resident's representative was made aware of a facility-initiated transfer, for one of four residents reviewed. (Residents R136)<br><br>Findings Include:<br><br>Review of nursing notes for Resident R136 dated April 21, 2024, at 11:37 p.m. revealed that the resident had a seizure and was transferred to a local hospital for evaluation at approximately 11:25 a.m.<br><br>Further review revealed a note, dated July 24, 2024, at 6:27 a.m., which indicated that Resident R136 was admitted to the local hospital for altered mental status on July 23, 2024.<br><br>Further record reviews for Residents R136 revealed that no documentation was available for review at | F 0623 | | |

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| F 0623<br><br>SS=D | Continued from page 5<br><br>the time of the survey to indicate that the Office of the State Long-Term Care Ombudsman was notified of the facility-initiated emergency transfers and discharges.<br><br>Review of documentation provided by the Social Services Director, Employee E9, on January 10, 2025, at 1:12 p.m., revealed the Office of the State Long Term Care Ombudsman was not made aware Resident R136's facility-initiated emergency transfers to the hospital as required.<br><br>Further interview confirmed that the facility failed to notify the residents representative of the transfer and reasons for the move in writing and in a language and manner they understand.<br><br>28 Pa. Code 201.14(a) Responsibility of licensee<br><br>28 Pa. Code 201.18(b)(2) Management | F 0623 | | |

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| F 0623<br><br>SS=D | Continued from page 6 | F 0623 | | |
| F 0625<br><br>SS=D | 483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr<br><br>§483.15(d) Notice of bed-hold policy and return-<br><br>§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-<br>(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;<br>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;<br>(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<br>(iv) The information specified in paragraph (e)(1) of this section.<br><br>§483.15(d)(2) Bed-hold notice upon transfer. At the time of 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.<br><br>This REQUIREMENT is not met as evidenced by: | F 0625 | R136 is now aware of MPACs bed hold Policy<br>The Social Services team have been educated by the NHA on the importance of adherence to regulations re: F625<br><br>All discharges transfers and discharges have been reviewed by social services staff for the past three months. There were no further discrepancies in notification of bed hold policy<br><br>Notification of resident representatives re: facility bed hold policy will be reviewed/audited monthly for accuracy by Social Services.<br><br>Results will be reported monthly in QAPI | Completion Date: **02/21/2025**<br>Status: **APPROVED**<br>Date: **01/28/2025** |

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| F 0625<br><br>SS=D | Continued from page 7 | F 0625 | | |

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| F 0625<br><br>SS=D | Continued from page 8<br><br>Based on clinical record review and interviews with staff, it was determined that the facility failed provide appropriate bed hold notice to a resident's representative of a facility-initiated transfer to the hospital for one of four residents reviewed related to transfers (Resident R136).<br><br>Findings include:<br><br>Review of Resident R136's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated February 26, 2024, revealed that the resident had severely impaired cognition.<br><br>Review of nursing notes for Resident R136 revealed a note, dated April 21, 2024, at 11:37 p.m. which indicated that the resident had a seizure and was transferred to a local hospital for evaluation at approximately 11:25 a.m.<br><br>Further review revealed a note, dated July 24, 2024, at 6:27 a.m., which indicated that Resident | F 0625 | | |

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| F 0625<br><br>SS=D | Continued from page 9<br><br>R136 was admitted to the local hospital for altered mental status on July 23, 2024.<br><br>Review of Resident R136's clinical record revealed that there was no bed hold notice available for review in the resident's record.<br><br>Interview with the Social Services Director, Employee E9, on January 10, 2025, at 1:12 p.m. confirmed that there were no documented evidence to indicate that Resident R136's representative was provided with written information that specified the duration of the state bed-hold policy at the time of the resident's transfer to the hospital.<br><br>Social Services Director, Employee E9 confirmed that there was no documentation available for review at the time of the survey to indicate that the resident or her representative was notified of the bed hold policy at the time of the resident's transfer to the hospital.<br><br>28 Pa Code 201.18(b)(2) Management | F 0625 | | |

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| F 0625<br><br>SS=D | Continued from page 10<br><br>28 Pa Code 211.5(f)(ix) Medical records<br><br>28 Pa Code 211.12(d)(1) Nursing services | F 0625 | | |
| F 0641<br><br>SS=D | 483.20(g) Accuracy of Assessments<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br><br>This REQUIREMENT is not met as evidenced by: | F 0641 | MDS has been corrected for R9 and R38<br><br>MDS coordinators or designees will audit all current MDS's to ensure there are no further discrepancies.<br><br>MDS coordinators will be in-serviced by NHA or designee on importance of assessment accuracy.<br><br>MDS audits will be conducted by MDS coordinators or designees to ensure assessment accuracy monthly for 3 months then quarterly thereafter.<br><br>Results will be reported in QA | Completion Date: **02/21/2025** Status: **APPROVED** Date: **01/28/2025** |

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| F 0641<br><br>SS=D | Continued from page 11<br><br>Based on observation, clinical record review and interview with staff, it was determined that the facility did not ensure that resident assessments accurately reflected resident status related to restraints for two of 34 records reviewed (Residents R9, R38).<br><br>Findings include:<br><br>Review of clinical documentation revealed that Resident R9 was most recently admitted to the facility on June 14, 2024, and had diagnoses of schizophrenia (a chronic mental illness characterized by a disconnect from reality, disorganized thinking and speech, and changes in behavior), anxiety, and dementia (progressive degenerative disease of the brain).. Review of the most recent MDS (Minimum Data Set- a periodic assessment of resident care needs) completed on September 22, 2024, revealed that in section P- Restraints and Alarms, it was documented that the resident's "chair prevents rising" and that this restraint was "used less than daily." | F 0641 | | |

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| F 0641<br><br>SS=D | Continued from page 12<br><br>Observations conducted on January 8, 2025, at 1:15 p.m. revealed that Resident R9 was ambulating at will through the unit.<br><br>During an interview with Employee E1, the Nursing Home Administrator, and Employee E2, the Director of Nursing, on January 9, 2025 at 1:13 p.m., they stated that the facility was "restraint-free" and confirmed that the resident has never had a restraint. They confirmed that the MDS was coded inaccurately.<br><br>Review of clinical documentation revealed that Resident R38 was admitted to the facility on July 22, 2014, and had diagnoses including Anxiety Disorder (mental health conditions that involve persistent and excessive feelings of fear or worry), Non-Alzheimer's Dementia ( Non-Alzheimer's Dementia can have complex symptoms that overlap with neurological and psychiatric disorders).<br><br>Review of the most recent MDS (Minimum Data Set- a periodic assessment of resident care needs) | F 0641 | | |

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| F 0641<br><br>SS=D | Continued from page 13<br><br>completed on October 8, 2024, revealed that in section P- Restraints and Alarms, it was documented that the resident R38 used "Limb Restraint" " in chair or out of bed", and that the restraint was "used less than daily".<br><br>Observations conducted on January 7, 2025, at 1:02 p.m., revealed that Resident R38 had no restraints.<br><br>Review of physician order for Resident R38 did not indicate any order for restraints. On January 7, 2025, at 1:02 p.m., during an interview Resident R38 stated that he never had any restraints.<br><br>During an interview with Employee E1, the Nursing Home Administrator, and Employee E2, the Director of Nursing, on January 9, 2025, at 1:13 p.m., they stated that the facility was "restraint-free" and confirmed that the resident has never had a restraint. They confirmed that the MDS was coded inaccurately. | F 0641 | | |

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| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
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| **MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK** | **4001 FORD ROAD PHILADELPHIA, PA 19131** |
| STATE LICENSE NUMBER: **041402** | |

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| F 0641<br><br>SS=D | Continued from page 14<br><br>28 Pa Code 211.5(f)(ix) Medical records<br><br>28 Pa. Code 211.12(d)(1) Nursing services | F 0641 | | |
| F 0644<br><br>SS=D | 483.20(e)(1)(2) Coordination of PASARR and Assessments<br><br>§483.20(e) Coordination.<br>A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:<br><br>§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.<br><br>§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.<br><br>This REQUIREMENT is not met as evidenced by: | F 0644 | R103 PASARR has been updated.<br><br>Social Services staff have been educated regarding the importance of ensuring that residents who have a new schizophrenia are reevaluated for a new or updated PASARR<br><br>ALL residents with PASARRs have been reviewed by social services staff and all are accurate and Up To Date<br><br>All Residents with PASARRs will be audited monthly x3 months by social services or designee to ensure they are up to date.<br><br>Results will be reported in monthly QAPI | Completion Date: **02/21/2025** Status: **APPROVED** Date: **01/28/2025** |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
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| F 0644<br><br>SS=D | Continued from page 15 | F 0644 | | |

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| F 0644<br><br>SS=D | Continued from page 16<br><br>Based on clinical record review and staff interview, it was determined that the facility failed to update Pennsylvania Pre-Admission Screening Resident Review (PASRR) of one resident with a new diagnosis of a serious mental disorder, out of 34 sampled residents reviewed (Residents R 103).<br><br>Findings include:<br><br>Review of Resident R103's clinical record revealed; the resident was admitted to the facility on March 4, 2021, and had diagnoses including Acute Kidney Failure (Acute kidney injury happens when the kidneys suddenly can't filter waste products from the blood; when the kidneys can't filter wastes, harmful levels of wastes may build up), Injury of Unspecified Body Region, and Type 2 Diabetes Mellitus (a disease that occurs when the body doesn't use insulin properly, resulting in high blood sugar levels).<br><br>Review of Pennsylvania Pre-Admission Screening Resident Review (PASRR- an in-depth mental health assessment to determine appropriate services | F 0644 | | |

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| F 0644<br><br>SS=D | Continued from page 17<br><br>and placement) Level I Form of R 103 indicated that it was completed on March 4, 2021. Under Section VIII -PASRR Level I Screening Outcome, it was stated that, individual has a negative screen for Serious Mental Illness, Intellectual Disability/Developmental Disability, or other related condition; no further evaluation (Level II) is necessary.<br><br>Further review of diagnosis sheet in the clinical records of R 103 revealed, on June 4, 2021, a new diagnosis of Undifferentiated Schizophrenia was included. (people with undifferentiated schizophrenia exhibit symptoms of more than one type of schizophrenia; these may include delusions, paranoia, hallucinations, and other symptoms that interfere with a person's sense of reality).<br><br>Additional review of clinical records did not provide any documented evidence to indicate that following the diagnosis of a new, serious mental disorder, the facility considered or addressed a referral to the appropriate state-designated authority | F 0644 | | |

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| F 0644<br><br>SS=D | Continued from page 18<br><br>for a Level II PASARR evaluation and determination; or to update the PASRR.<br><br>During an interview on January 9, 2025, at 10: 52 a.m., the Director of Social Services, Employee E9, confirmed the above stated finding.<br><br>28 Pa. Code 211.5(f)(iv) Medical records | F 0644 | | |
| F 0656<br><br>SS=D | | F 0656 | | |

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| F 0656<br><br>SS=D | Continued from page 19<br><br>483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan<br><br>§483.21(b) Comprehensive Care Plans<br>§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 -<br>(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<br>(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).<br>(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.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future | F 0656 | Care plans for R7, R28, R155 have been updated to reflect dementia, smoking and pain management as appropriate.<br><br>All residents' care plans have been reviewed and updated.<br><br>Unit managers will be educated by staff development or designee on the importance of ensuring up to date and accurate care plans.<br><br>Care plans will be audited by unit managers or designee monthly x 3 months then quarterly thereafter.<br><br>Results will be reported in monthly QAPI | Completion Date: **02/21/2025**<br>Status: **APPROVED**<br>Date: **01/28/2025** |

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| F 0656<br><br>SS=D | Continued from page 20<br><br>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.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br><br>This REQUIREMENT is not met as evidenced by: | F 0656 | | |

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| F 0656<br><br>SS=D | Continued from page 21<br><br>Based on observation, clinical record review and interview with staff and residents, it was determined that the facility did not develop a comprehensive care plan related to dementia, smoking, and pain management for 3 of 34 records reviewed (Residents R7, R28, R155).<br><br>Findings include:<br><br>Review of clinical records revealed that Resident R7 was admitted to the facility on March 20, 2018, and had diagnoses that included Type 2 Diabetes Mellitus (a disease that occurs when the body doesn't use insulin properly, resulting in high blood sugar levels), and Dementia (a general term for a group of brain conditions that cause a decline in mental abilities).<br><br>Review of Resident R7's current care plan revealed that there was no care plan was developed for the dementia care.<br><br>During an interview with the Nursing Home | F 0656 | | |

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| F 0656<br><br>SS=D | Continued from page 22<br><br>Administrator, and the Director of Nursing, on January 13, 2025, at 12:20 p.m., it was confirmed that no care plan was developed for the Dementia care needs of Resident R7.<br><br>Observations conducted on January 10, 2025, at 9:53 a.m. revealed that the Resident R28 went to smoke breaks and was a smoker.<br><br>Review of Resident R28's current care plan revealed that there was no care plan was developed for safety during smoking for Resident R28..<br><br>Interview with the Unit manger, Nurse Employee E14, on January 10, 2025, 11:40 a.m. revealed that Resident R28 was a smoker and was not sure why Resident R28 was not care planned for smoking.<br><br>Observations conducted on January 8, 2025, at 1:30 p.m. revealed that the Resident R155 appeared to be in pain, with facial grimacing and | F 0656 | | |

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| F 0656<br><br>SS=D | Continued from page 23<br><br>negative verbalizations noted.<br><br>Review of clinical documentation revealed that Resident R155 was most recently admitted to the facility on October 26, 2024, and had diagnoses that included, prostate cancer, and septic pulmonary embolism (a blood clot in the lung which had become infected).<br><br>Review of the resident's physician orders revealed that the resident had an order for hospice services dated November 1, 2024, related to his stage 4 prostate cancer. In addition, medications were ordered for pain management, including "Gabapentin Capsule 300 MG (milligrams) Give 1 capsule by mouth three times a day for pain", dated October 26, 2024, and "Morphine Sulfate (Concentrate) Solution 20MG/ML Give 0.25 ml by mouth every 3 hours as needed for pain", dated November 1, 2024. Review of the resident's care plan revealed that no care plan had been developed to address pain related to cancer diagnosis. | F 0656 | | |

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| F 0656<br><br>SS=D | Continued from page 24<br><br>During an interview with Employee E1, the Nursing Home Administrator, and E2, the Director of Nursing, on January 13, 2025 at 12:25 p.m., they stated that it was the expectation of the facility that a care plan should be developed for all resident care needs and confirmed that none was developed for pain for Resident R155.<br><br>28 Pa Code 211.11(d) Resident care plan<br><br>28 Pa Code 211.12(d)(1) Nursing services | F 0656 | | |
| F 0657<br><br>SS=D | | F 0657 | | |

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| F 0657<br><br>SS=D | Continued from page 25<br><br>483.21(b)(2)(i)-(iii) Care Plan Timing and Revision<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br><br>This REQUIREMENT is not met as evidenced by: | F 0657 | The Care plan is revised as appropriate for R31<br><br>DON or designee will conduct In-service education on the importance of updated and accurate care plans<br><br>Unit managers or designees will update all residents' care plans who have pacemakers, to ensure that they reflect the resident's current pacemaker status.<br><br>Care plans will be audited by unit managers or designee monthly x 3 months then quarterly thereafter.<br><br>Results will be reported in monthly QAPI | Completion Date: **02/21/2025** Status: **APPROVED** Date: **01/28/2025** |
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| F 0657<br><br>SS=D | Continued from page 26<br><br>Based on clinical record review and interview with staff, it was determined that the facility did not ensure that care plans were updated in a timely manner for one of 34 records reviewed related to hospice (Resident R31).<br><br>Findings include:<br><br>Review of clinical documentation revealed that Resident R31 was admitted to the facility on September 18, 2017, and had diagnoses including, congestive heart failure (an accumulation of fluid around the heart which makes it more difficult for the heart to beat effectively), ventricular tachycardia (a heart rhythm where the ventricles constrict abnormally fast, putting the resident at risk of cardiac arrest), and presence of pacemaker (a device implanted into the chest to regulate heart rhythm).<br><br>Further review revealed a physician order dated October 10, 2023, which read "Pacemaker ...to be turned off due to hospice status". Review of the care | F 0657 | | |

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| F 0657<br><br>SS=D | Continued from page 27<br><br>plan revealed that it had been updated that same day to read the same. A physician order was found to discontinue hospice care dated December 2, 2024. As of January 10, 2025, the care plan had not been updated to reflect this change in status as it related to the resident's pacemaker.<br><br>Interview with Employee E1, the Nursing Home Administrator, and Employee E2, the director of nursing, on January 13, 2025, at 2:15 p.m. revealed that the expectations of the facility are that care plans are to be reviewed and updated timely with every major change, including signing on to or discontinuing hospice care. It was confirmed that this care plan item had not been updated as required.<br><br>28 Pa. Code 211.10 (d) Resident care policies<br><br>28 Pa. Code 211.12 (d)(5) Nursing services | F 0657 | | |

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|---|---|---|---|
| | 396076 | A. BLDG: 00<br>B. WING: | 01/13/2025 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
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| **MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK**<br>STATE LICENSE NUMBER: **041402** | **4001 FORD ROAD PHILADELPHIA, PA 19131** |

| (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 0726<br><br>SS=D | 483.35(a)(3)(4)(c) Competent Nursing Staff<br><br>§483.35 Nursing Services<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.<br><br>§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br><br>§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.<br><br>§483.35(c) Proficiency of nurse aides.<br>The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br><br>This REQUIREMENT is not met as evidenced by: | F 0726 | Staff Educator conducted competency assessments for licensed nurses. Licensed Nurses who currently work in the facility now have skills competency evaluations for: Medication Administration, Dementia and Behaviors, Urinary Catheters, Tracheostomy care, wound Care and Abuse prevention and reporting.<br><br>Staff Educator or Designee will conduct Skills competency evaluations for all licensed nurses at least annually.<br><br>Staff Educator or Designee will conduct Skills competency evaluation audits Quarterly.<br><br>Results will be kept on file and reported on Monthly QAPI | Completion Date: **02/21/2025**<br>Status: **APPROVED**<br>Date: **01/28/2025** |

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| F 0726<br><br>SS=D | Continued from page 29<br><br>Based on review of personnel records and interview with staff, it was determined that the facility did not provide requested evidence of competency trainings for licensed nursing staff.<br><br>Findings include:<br><br>On January 10, 2024, at 1:45 p.m. the surveyor requested skills competency evaluations for Licensed Nurses. The requested skills were to be related to medication administration, dementia and behavioral, catheter, tracheostomy care, wound care, and abuse prevention and reporting.<br><br>In an interview on January 10, 2024, at 1:54 p.m. with Educator, Employee E12, stated that the facility was unable to supply the surveyor with all the requested skills competencies for the nurses, stating that they "didn't have" them.<br><br>28 Pa. Code: 211.12(d)(1) Nursing services<br><br>28 Pa. Code 211.12(d)(5) Nursing services | F 0726 | | |

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|---|---|---|---|---|
| F 0726<br><br>SS=D | Continued from page 30 | F 0726 | | |
| F 0755<br><br>SS=D | 483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records<br><br>§483.45 Pharmacy Services<br>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.<br><br>§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.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§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<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and | F 0755 | All medication for R162 have been destroyed<br><br>The Staff educator or designee will In-service all Licensed nurses on the importance of timely disposal of medications after discharge.<br><br>All Medication Carts and Medication rooms were inspected by unit managers and there are no further incidents of untimely disposal of medication.<br><br>Unit managers or designees will conduct audits on discharge residents weekly for 4 weeks to ensure timely disposal of medications<br><br>Results will be reported in monthly QAPI | Completion Date: **02/21/2025**<br>Status: **APPROVED**<br>Date: **01/28/2025** |

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| F 0755<br><br>SS=D | Continued from page 31<br><br>periodically reconciled.<br><br>This REQUIREMENT is not met as evidenced by: | F 0755 | | |

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| F 0755<br><br>SS=D | Continued from page 32<br><br>Based on closed clinical record review, and interviews with staff, it was determined that the facility failed to ensure that controlled medications were disposed in a timely manner for one of 3 closed records reviewed (Resident R162).<br><br>Findings include:<br><br>Review of clinical documentation for Resident R162 revealed that she was admitted to the facility on September 23, 2024, and discharged from the facility against medical advice on October 24, 2024. While a resident, she had an order for "Morphine Sulfate (Concentrate) Solution 20 MG/ML Give 0.25 milliliter by mouth every three hours as needed for Pain/SOB hospice", and "Lorazepam Concentrate 2 MG/ML Give 0.25 milliliter by mouth every 6 hours as needed for anxiety/agitation". Morphine is a Schedule 2 controlled medication, which are classified as high potential for misuse, dependence, and addiction. Lorazepam is a schedule 4 controlled substance which has a lower | F 0755 | | |

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| F 0755<br><br>SS=D | Continued from page 33<br><br>potential for abuse than schedule 2 substances, however, the abuse of a schedule 4 medication may lead to physical or psychological dependence.<br><br>Further review of resident records revealed a nursing note from January 9, 2025, which stated "Resident discharged home. All medications: albuterol sulfate neb 2.5 mg/3 ml #4, fluticasone Propionate suspension 50 mg/act #1, hyoscyamine sulfate 0.125 mg #4, loratadine 10 mg #6, lorazepam 2 mg/ml #20 ml, losartan potassium 25 mg #6, morphine sulfate 20 mg/ml #15 ml, prochlorperazine 10 mg #5, vitamin d3 1250 mcg #6, triamterene & hydrochlorothiazide 37.5-25 mg #7. All medications counted and destroyed." The "Controlled Medication Accountability" forms for both the morphine and the lorazepam were signed as "wasted/destroyed" on January 9, 2025.<br><br>Interview with the Director of Nursing, Employee E2, on January 13, 2025, at 1:30 p.m. confirmed that the medications for Resident R162 had not been disposed of until January 9, 2025, 11 weeks | F 0755 | | |

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| F 0755<br><br>SS=D | Continued from page 34<br><br>after the resident was discharged, which Employee E2 confirmed was not considered to be a timely manner.<br><br>28 Pa Code 211.9(a)(1) Pharmacy services<br><br>28 Pa Code 211.12(d)(5) Nursing services | F 0755 | | |
| F 0812<br><br>SS=E | | F 0812 | | |

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| F 0812<br><br>SS=E | Continued from page 35<br><br>483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>This REQUIREMENT is not met as evidenced by: | F 0812 | The Soapy water and bucket were removed immediately. The dishes were removed from the tray line. The Ground Beef and chicken have since been labeled and used.<br><br>All other Food items in the kitchen have been inspected by Food Services Director and dated as appropriate.<br><br>The Food Services Director or Designee will In-service dietary staff on importance of sanitation practices, using the drying rack for dishes, and labeling and dating items when pulled.<br><br>The Dietary Director or designee will conduct Kitchen inspections weekly for 4 weeks to ensure compliance.<br><br>Results will be reported in monthly QAPI. | Completion Date: **02/21/2025**<br>Status: **APPROVED**<br>Date: **01/28/2025** |

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| F 0812<br><br>SS=E | Continued from page 36<br><br>Based on observations, interviews with staff, and a review of facility procedures, it was determined that the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety.<br><br>Findings include:<br><br>Review of facility policy titled, Storage of Refrigerated Foods Policy, revised March 9, 2024, indicated that staff must "label and note pull date on all food items when removing from freezer." Further review revealed that refrigerated food held for more than 24 hours will be marked to indicate the date the food will be consumed or discarded.<br><br>A follow-up tour of the main kitchen was conducted on Thursday, January 9, 2025, at 10:45 p.m. with the Food Service Director (FSD), Employee E13.<br><br>Observations at 10:46 a.m. revealed a bucket with soapy water and rag was standing on the preparation table in the cooking area meanwhile the | F 0812 | | |

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| F 0812<br><br>SS=E | Continued from page 37<br><br>cook was assembling sandwiches.<br><br>Observations of the main refrigerator at 10:50 p.m. revealed three rolls of 10-pound ground beef, a bag of raw mixed chicken, and a bag of raw chicken thighs were unlabeled and undated. Interview with the FSD revealed that the ground beef rolls, mixed chicken, and chicken thighs were pulled from the freezer to thaw on Tuesday, January 7, 2025. Further interview acknowledged that these food items should have been dated with a pull date.<br><br>Further observations at 10:55 p.m. revealed dishes were drying on the tray line with limited all-around airflow. Prepared hot food was observed on the tray line by the drying dishware. Follow up interview confirmed that drying racks should have been utilized to allow proper draining and all-around airflow.<br><br>28 Pa. Code: 201.14(a) Responsibility of licensee.<br><br>28 Pa. Code 201.18(b)(3) Management | F 0812 | | |

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| F 0812<br><br>SS=E | Continued from page 38 | F 0812 | | |
| F 0814<br><br>SS=E | 483.60(i)(4) Dispose Garbage and Refuse Properly<br><br>§483.60(i)(4)- Dispose of garbage and refuse properly.<br><br>This REQUIREMENT is not met as evidenced by: | F 0814 | The recycling container has since been emptied and no other trash or garbage container on facility property is overflowing.<br><br>Dietary, housekeeping and maintenance staff will be in- serviced by staff the educator or designee on importance of breaking down boxes prior to dumping in the recycle bin.<br><br>Dietary Director or Designee will conduct observations weekly times 4 weeks to ensure that the recycle bin not overflowing.<br><br>Results will be reported in monthly QAPI. | Completion Date: **02/21/2025** Status: **APPROVED** Date: **01/28/2025** |

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| F 0814<br><br>SS=E | Continued from page 39<br><br>Based on observations and an interview with staff, it was determined that the facility did not ensure that garbage and refuse was disposed of properly.<br><br>Findings include:<br><br>An initial tour of the Food Service Department was conducted on Tuesday, January 7, 2025, at 9:57 a.m. with Employee E16, Cook, which revealed that the blue dumpster was fully open and overflowing with cardboard boxes. Additional piles of cardboard and boxes was observed on the ground on all four sides of the dumpster.<br><br>Follow up observation with the Food Service Director (FSD), Employee E13, conducted on Thursday, January 9, 2025, at 10:32 a.m. revealed that the blue dumpster remained fully open and overflowing with cardboard and carboard boxes. Additional piles of cardboard and boxes was observed on the ground on all four sides of the dumpster. | F 0814 | | |

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| F 0814<br><br>SS=E | Continued from page 40<br><br>Interview with the FSD at 10:32 a.m. on Thursday, January 9, 2025, confirmed the above findings.<br><br>28 Pa. Code: 201.14(a) Responsibility of licensee.<br><br>28 Pa. Code 201.18(b)(3) Management | F 0814 | | |
| F 0880<br><br>SS=D | | F 0880 | | |

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| F 0880<br><br>SS=D | Continued from page 41<br><br>483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or<br>infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported; | F 0880 | PPE is now worn for high contact activities with R113<br><br>All residents who are on Enhanced Barrier precautions have been reviewed by DON/ educator. PPE is available on the unit for all residents who require use during high contact activities.<br><br>Licensed nurses will be in-serviced by the educator or designee on the importance of wearing PPE for high contact activities with residents who are on Enhanced Barrier Precautions Staff educators or designee will random audits during resident care weekly times 4 weeks to ensure PPE is being used appropriately.<br><br>Results will be reported in monthly QAPI | Completion Date: **02/21/2025** Status: **APPROVED** Date: **01/28/2025** |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 396076 | A. BLDG: __00_____ B. WING: _____ | 01/13/2025 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
|---|---|
| **MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK** STATE LICENSE NUMBER: **041402** | **4001 FORD ROAD PHILADELPHIA, PA 19131** |

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|---|---|---|---|---|
| F 0880<br><br>SS=D | Continued from page 42<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br><br>This REQUIREMENT is not met as evidenced by: | F 0880 | | |

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| F 0880<br><br>SS=D | Continued from page 43 | F 0880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
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| F 0880<br><br>SS=D | Continued from page 44<br><br>Based on observations, review of facility policies, review of facility documentation, clinical record review and interviews with staff, it was determined that the facility failed to maintain an effective infection control program related with Transmission Based Precautions for one of 34 residents reviewed ((Resident R113).<br><br>Findings include:<br><br>Review of literature review revealed that Enhanced Barrier Precautions are infection control interventions designed to reduce the transmission of novel or Multi-Drug Resistant Organisms. Enhanced Barrier Precautions require to employ the use of targeted personal protective equipment (PPE) during high contact patient/resident activities.<br><br>On January 10, 2025, at 2:39 p.m., review of the door of the room of Resident R113 revealed a guiding description pasted on it, indicating that Resident R113 was on Enhanced Barrier Precautions. | F 0880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
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|---|---|---|---|---|
| F 0880<br><br>SS=D | Continued from page 45<br><br>Review of the physician order for Resident R113 revealed that Resident R113 had an order dated July 11, 2024, to Cleanse G-tube site daily with soap and water, every day-shift.<br><br>Observation on January 10, 2025, at 2:41 p.m., revealed that a Licensed Nurse, Employee E17, was cleansing Resident R113's G-tube site. Employee E17 did not wear PPE, even though Resident R113 was on Enhanced Barrier Precautions; and the same information was noted on the door of the resident room. At the time of the finding, the observation was confirmed with Employee E17.<br><br>28 Pa Code 211.10(d) Resident care policies<br><br>28 Pa. Code 211.12(d)(1) Nursing services | F 0880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
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| | 396076 | A. BLDG: 00<br>B. WING: | 01/13/2025 |

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|---|---|---|---|---|
| P 5640 | Nursing services.<br><br>(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.<br><br>This REGULATION is not met as evidenced by: | P 5640 | The multidisciplinary team has reviewed the dates: January 3rd, 4th, 5th, and 6th. There were no resident negative outcomes as a result of substandard staffing on those days.<br><br>DON or designee will calculate PPD daily for accuracy prior to the start of the day.<br><br>Daily PPD will be documented and kept on file for ongoing review and reporting.<br><br>DON or designee will review all PPDs for the past 3 months to ensure none were below the current required minimum of 3.2.<br><br>Results will be reported in Montly QAPI | Completion Date: **02/21/2025**<br>Status: **APPROVED**<br>Date: **02/05/2025** |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
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| P 5640 | Continued from page 1<br><br>Based on a review of nursing staffing hours and staff interview, it was determined that the facility did not ensure a minimum of 3.2 nursing care hours per patient, per day, on four of 21 days reviewed (January 3,4,5,and 6, 2025)<br><br>Findings include:<br><br>Review of nursing staff care hours provided by the facility revealed the following staff scheduled for the resident census:<br><br>On January 3, 2025, 509 care hours with a census of 164 residents, totaling 3.1 PPD.<br><br>On January 4, 2025, 502 care hours with a census of 165 residents, totaling 3.04 PPD.<br><br>On January 5, 2025, 524.5 care hours with a census of 165 residents, totaling 3.18 PPD.<br><br>On January 6, 2025, 507.5 care hours with a census of 161 residents, totaling 3.15 PPD. | P 5640 | | |

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| P 5640 | Continued from page 2<br><br>Interview with Employee E1, the Nursing Home Administrator, on January 13, 2025, at 2:30 p.m., confirmed that the above staffing levels did not meet the required minimums. | P 5640 | | |

# Certified End Page

**MONUMENTAL POST ACUTE CARE AT WOODSIDE PARK**

**STATE LICENSE NUMBER: 041402**

**SURVEY EXIT DATE: 01/13/2025**

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

Jeanne Parisi
*Deputy Secretary for Quality Assurance*

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

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

## PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY