STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396143	A. BLDG: 00 B. WING:	12/12/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ARISTACARE AT EAST FALLS STATE LICENSE NUMBER: **24780201**	**3300 HENRY AVENUE, 7TH FLOOR** **PHILADELPHIA, PA 19129**

(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 State Licensure survey, and Civil Rights Compliance and two abbreviated survey completed on December 12, 2025, it was determined that Aristacare at East Falls was not in compliance with the following 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 0677 SS=D		F 0677		

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 0677 SS=D	Continued from page 1 483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 0677	1. Identified Residents had no negative outcome from not receiving ADL care. 2. Director of nursing or designee audited current residents to ensure ADL was provided for the past seven days. 3. Audits will be conducted by the Director of Nursing/designee of ten random residents who require ADL assistance to ensure they received care and will audit their documentation to ensure it reflects accordingly, weekly x 4 and then monthly x 3. Education will be provided to facility nursing staff regarding the Nursing Policy Activities of Daily Living (ADLs) and nursing assistant shift responsibilities. 4. Results of the audits will be reported to the QAPI committee.	Completion Date: **12/16/2025** Status: **APPROVED** Date: **12/16/2025**

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F 0677 SS=D	Continued from page 2 Based on interviews with residents and staff and review of clinical records, it was determined the facility failed to provide residents who is unable to carry out activities of daily living receives the necessary services to maintain personal hygiene related to incontinence care for four of 14 resident records reviewed (Resident R12, R17, R18, and R19). Findings include: Review of Resident R12's clinical records revealed an admission date of March 6, 2025, with the diagnoses of nontraumatic intracranial hemorrhage (bleeding), dysphagia (unable to swallow) following unspecified cerebrovascular disease, tracheostomy status, acute and chronic respiratory failure, hypertension, and gastrostomy. Review of Resident R12's annual MDS (minimum data set-an assessment of resident care needs) dated August 24, 2025. assessed the resident ' s cognition as severely impaired and completely dependent on staff for all activities of daily needs. During observation of Resident R12 receiving care by Nurses Aides (NA) Employee E9 and E10 on November 4, 2025, at 10:30 a.m. NAs stated Resident R12 was checked every two for incontinence, then it was documented it the resident was incontinent and what type of care was	F 0677		

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F 0677 SS=D	Continued from page 3 provided. Review of Resident R12 Bowel and Bladder Diary initiated on August 21, 2024, instructed the NA to document the resident ' s incontinence status " Upon rising, after meals, at bedtime and as needed, every day, every shift: day, night, evening, nights 10-6. " Review of the documentation revealed on October 16, 2025, at 2208 (10:08 p.m.) was the last time Resident R12 was documented receiving incontinence care, and not until, approximately 24 hours later, on October 17, 2025, at 2228, (10:29 p.m.) the resident was found and documented wet with bowel movement. On November 6, 2025, at 11:00 a.m. during an interview with three residents (Resident R17, R18, R19), alert and oriented, dependent on staff for incontinence care revealed complaints/concerns related to untimely incontinence care. Resident R18 stated, " This past weekend, I had to lay in a saturated brief until morning. It happens often. " Resident R17 stated, " Call bell response is horrible. 7-3 and 3-11 will walk right by and pretend they don ' t know you need them. 11-7 they are not even in sight. When they do come, they have an attitude. Resident R19 stated, " I had a yeast infection from not being changed properly. " Resident R17 and Resident R19 both stated they and their	F 0677		

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F 0677 SS=D	Continued from page 4 daughters have complained multiple times to the facility. They both agreed that the facility says they will, " Look into it ' , do something, ' Talk to the staff ' , but nothing changes. " 28 Pa. Code 211.12(c)(d)(3)(5) Nursing services	F 0677		
F 0686 SS=D	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 0686	1. Identified resident had their pressure relieving devices immediately applied. 2. Audit of all residents with orders for pressure relieving devices to the heels to ensure device in place. 3. Random Weekly x 4 then Monthly x 3 audits by DON or designee of pressure wound prevention devices for the heels to ensure compliance with interventions/orders. CNA staff educated on pressure wound prevention devices for the heels. 4. Results of the audits will be reported to the QAPI committee.	Completion Date: **12/16/2025** Status: **APPROVED** Date: **12/16/2025**

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F 0686 SS=D	Continued from page 5	F 0686		

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F 0686 SS=D	Continued from page 6 Based on observation, interviews with staff, review of clinical records revealed the facility failed to ensure a resident at risk for pressure ulcers received care, consistent with professional standards of practice, to prevent pressure ulcers for one of 14 resident records reviewed (Resident R12). Findings include: Review of Resident R12's clinical records revealed an admission date of March 6, 2025, with the diagnoses of nontraumatic intracranial hemorrhage (bleeding), dysphagia (unable to follow) following unspecified cerebrovascular disease, tracheostomy status, acute and chronic respiratory failure, hypertension (high blood pressure), and gastrostomy. Physician orders dated September 12, 2025, instructed to don Prevalon boots (offloads pressure to reduce skin injuries) in bed/chair every day and night shift. Review of Resident R12's nursing notes dated October 29, 2025, stated the resident was found with an open area noted to right posterior lower leg above the ankle. The wound was documented measurements were, " length 5.0, Width 2.5, and roughly 0.5 in Depth. " Observation of Resident on November 3, 2025, and	F 0686		

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F 0686 SS=D	Continued from page 7 November 4, 2025, at 9:00 a.m. revealed that there were no Prevalon boots worn by the resident. November 4, 2025, at 10:30 a.m. during an interview with nurses ' aides (NA) Employee E9 and E10, the resident continued to be observed without Prevalon boots. NAs Employee E9 and E10 stated that a blister formed on the resident ' s leg and it popped. The aides stated the resident likes to cross his legs. Due to the boots not being used the resident was able to cross his legs which the area the two legs met was in the same area where the wound was found. The Director of Nursing was made aware of the above findings on November 4, 2025 at 11:00 a.m. 28 Pa. Code 211.12 (d)(5) Nursing Services.	F 0686		
F 0688 SS=D		F 0688		

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F 0688 SS=D	Continued from page 8 483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 0688	1. Resident R12 had gauze applied per physician orders. 2. Other Residents with splints were checked for proper appliance per physician orders. 3. Random audits will be conducted by DON or designee weekly x4 and monthly x3 to ensure proper application of splints/devices per orders. 4. Results of the audits will be reported to the QAPI committee.	Completion Date: **12/16/2025** Status: **APPROVED** Date: **12/16/2025**

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F 0688 SS=D	Continued from page 9 Based on observation, interviews with staff and review of resident clinical records, it was determined that the facility failed to ensure a resident with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion related to splinting for one of 14 resident records reviewed (Resident R12). Findings include: Review of Resident R12's clinical records revealed an admission date of March 6, 2025, with the diagnoses of nontraumatic intracranial hemorrhage (bleeding), and tracheostomy status. Review of Resident R12 ' s physician orders dated August 22, 2025, instructed to place a clean rolled gauze in right hand for passive stretch and in the left hand a carrot orthosis up to six hours on for contracture management. Review of Resident R12's care plan revealed that a care plan was developed on October 30, 2023 for a resting hand splints to be worn during daytime for 6-8 hours. Observation of Resident R12 on November 4, 2025, at 10:30 a.m., with nurses ' aide (NA) Employee E9 and E10, revealed there was no rolled gauze in place on the resident's right hand. Interview with NA, Employee E9 at the time of the	F 0688		

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F 0688 SS=D	Continued from page 10 observation revealed that the gauze was for wound care and the wound care nurse would place the gauze in the residents hand. Interview conducted with the Director of Rehabilitation on November 6, 2025, at 10:00 a.m. revealed that the gauze that was to be placed on the resident's right hand was used for contractures not for wound care. 28 Pa. Code 211.12 (d)(5)(5) Nursing Services.	F 0688		
F 0689 SS=E	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	1. Identified residents were immediately provided with fall mats as care planned. 2. Residents with care plan for fall mats were audited to ensure the fall mats were properly in place. 3. Random audits will be conducted weekly x 4 and monthly x3 for residents with an order for floor mats to ensure placement as indicated. 4. Results of the audits will be reported to QAPI committee for results, areas of improvement and/or continuation of audits.	Completion Date: **12/16/2025** Status: **APPROVED** Date: **12/16/2025**

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F 0689 SS=E	Continued from page 11 Based on review of clinical records, observations, and staff interviews, it was determined that the facility failed to ensure safety interventions for falls were in place for two of four residents reviewed for falls (Resident R11, R20). Findings include: Clinical record review revealed Resident R11 was admitted to the facility on September 24, 2024 with a diagnosis of chronic obstructive pulmonary disease (condition that prevents airflow to the lungs, causing breathing problems), hemiplegia and hemiparesis (affects movement/sensation on one side of body), and cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it). Review of Resident R11 ' s care plan, revised September 19, 2025, revealed the resident is at moderate risk for falls related to confusion, deconditioning, and unaware of safety needs. The resident subtantiated a fall that occurred on September 02, 2025 when resident slid out of wheelchair and another fall from bed on September 16, 2025. Further review of Resident R11 ' s care plan for falls revealed fall mats were to be applied to bilateral sides of the bed.	F 0689		

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F 0689 SS=E	Continued from page 12 Observation on November 03, 2025 at 10:12 a.m. revealed Resident R11 lying in bed and did not have bilateral floor mats on the floor next to the bed. Follow-up observation on November 03, 2025 at 1:10 p.m. revealed Resident R11 lying in bed and did not have bilateral floor mats on the floor next to the bed. Interview on November 03, 2025, at 1:22 p.m., with Employee E7, Nurse Aide, confirmed Resident R11 did not have bilateral floor mats on the floor while in bed. Review of clinical record revealed Resident R20 was admitted to the facility on October 30, 2024, with a diagnose of amyotrophic lateral sclerosis (also known as " Lou Gehrig ' s Disease, " a neurodegenerative disease affecting nerve cells in the brain and spinal cord, which leads to loss of muscle control) and myasthenia gravis (chronic autoimmune disorder leading to muscle weakness and fatigue). Review of Resident R20 ' s care plan, initiated May 17, 2025, revealed Resident R20 was at risk for falls and interventions included bilateral fall mats to be in place. Observation on November 05, 2025 at 11:30 AM revealed Resident R20 had one fall mat on the right side of the bed in place.	F 0689		

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F 0689 SS=E	Continued from page 13 Interview with Employee E8, Licensed Practical Nurse, confirmed Resident R20 only had the right-side fall mat in place. 28 Pa. Code 211.12 (d)(5) Nursing Services.	F 0689		
F 0699 SS=D	483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by:	F 0699	1. Resident R7 care plan was immediately updated to include PTSD. 2. Residents with a d/x of PTSD care plan will be reviewed/updated to include possible triggers. 3. Care plans for residents with a d/x of PTSD will be audited/implemented and interviewed for triggers. New admissions will be audited for PTSD d/x and triggers, 2x week for 2 weeks and then 1x week for 3 weeks. 4. Audits will be submitted to the QAPI committee for review.	Completion Date: **12/16/2025** Status: **APPROVED** Date: **12/16/2025**

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F 0699 SS=D	Continued from page 14 Based on review of clinical records, facility policy, and staff interview, it was determined that the facility failed to provide culturally competent, trauma care in accordance with professional standards of practice, accounting for the resident's past experiences and preferences in order to eliminate and/or mitigate triggers that may cause re-traumatization of the resident for one of two residents sampled for post-traumatic stress disorder(PTSD). (Resident R7). Findings include: A review of the clinical record revealed that Resident R7 was admitted to the facility on July 07, 2024 with diagnoses to include traumatic subarachnoid hemorrhage (a collection of blood that accumulates between the inner layer of the skull), traumatic brain injury (occurs when external force causes damage to the brain), and post-traumatic stress disorder (PTSD) (a mental health condition that develops after experiencing or witnessing a traumatic event, such as a natural disaster, war,	F 0699		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396143	A. BLDG: 00 B. WING:	12/12/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ARISTACARE AT EAST FALLS STATE LICENSE NUMBER: **24780201**	**3300 HENRY AVENUE, 7TH FLOOR PHILADELPHIA, PA 19129**

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F 0699 SS=D	Continued from page 15 violent crime, or personal loss). Resident R7's care plan, initiated July 08, 2025, revealed no care plan was developed for history of traumatic events. Further review of the care plan did not address possible triggers that may cause re-traumatization. Interview with the Director of Nursing, Employee E2, on November 06, 2025 at 11:30 a.m., confirmed Resident R7 ' s care plan was developed for the resident ' s diagnosis of PTSD and possible triggers that may cause re-traumatization. 28 Pa. Code 211.12(c)(d)(3)(5) Nursing services	F 0699		
F 0919 SS=E		F 0919		

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F 0919 SS=E	Continued from page 16 483.90(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	1. Corrective actions are currently in process. 2. Maintenance/designee will complete an initial audit on all call bell systems on each wing. 3. Maintenance will complete random audits weekly x4 and monthly x2 to ensure the call bell system is functioning properly. 4. Findings will be reported to the QAPI committee	Completion Date: **12/16/2025** Status: **APPROVED** Date: **12/16/2025**

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 0919 SS=E	Continued from page 17 Based on observation, interviews with residents and staff, and review of facility documentation, it was determined that the facility failed to ensure that call bells were functioning properly for 6 of 6 resident rooms. (Rooms-717 (A and B), 723, 720-(A and B), 728-B and 733-B) Findings include: Review of Facility ' s policy for Call Bells revealed (within Item 3 of Guidelines) that " For any defective call lights, inform maintenance. Residents may be offered with a tap bell to use if and when applicable. " Observations on November 5, 2025, at 11:30 AM and November 7, 2025, at 11:35 AM of call light of Residents ' call bell in room 717-A and B, revealed that at both times call bell box had been pulled out of the wall and was therefore rendered defective/ineffective. Further observation revealed that the call bell did not illuminate outside room	F 0919		

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F 0919 SS=E	Continued from page 18 when the resident pushed call bell button, Resident R20 had not been provided with an alternative of a tap bell as per facility Call Bells Policy. Observation and interview with Resident R21 on November 4, 2025, at 12:00 p.m. stated the resident ' s call bell in room 723-B has not worked in months. Observed was a small silver manual bell that the resident was told to use if staff attention was needed. Review of a grievance, dated October 17, 2025 family reported Resident R22 ' s call bell in room 731 has not worked in approximately two weeks since the resident ' s admission, instead was giving a manual bell. On November 6, 2025, at 11:00 a.m. during an interview with four residents (Resident R17, R18, R19 and R23), in rooms 720-A and B, 728-B and 733-B stated their call bells have not worked for weeks. They are given a small manual bell that the	F 0919		

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 0919 SS=E	Continued from page 19 staff do not respond. On November 4, 2025, at 1:00 p.m. during an interview with the Nursing Hime Administrator, stated the facility does not have an effective process for informing maintenance when something needs repair. Maintenance is told verbally and that recently the staff was trained on how to use the computerized TELS system that goes directly to maintenance. 28 Pa Code 201.18(b)(3) Management	F 0919		

Certified End Page

ARISTACARE AT EAST FALLS

STATE LICENSE NUMBER: 24780201

SURVEY EXIT DATE: 12/12/2025

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