STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395110	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Healthcare & Rehabilitation Center	2109 Red Lion Road Philadelphia, PA 19115

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 43923 Based on observation and an interview with staff, it was determined that the facility failed to ensure that the Department of Health Survey results were readily accessible to residents and visitors on three of three nursing units. (A, B, C nursing units) Findings Include: On August 27, 2024, at 10:36 a.m. a resident group meeting was held with nine alert and oriented residents (R75. R115, R83, R83, 51, R55, R34, R4, R99, R48) who reported that they were not aware of the survey results binder and were not aware of the location where the survey results binder would be located and available to review. Observation on August 27, 2024, at 11:27 a.m. revealed the survey binder was in the main lobby behind the receptionist desk. Further observation with the Nursing Home Administrator, Employee E1 revealed the survey binder on nursing units A, B, C were all behind the nursing station desk which confirmed that residents do not have access and it is not readily accessible to residents. Interview on August 27, 2024, at 11:27 with Nursing Home Administrator, Employee E1 confirmed the state survey results were not readily accessible for resident, families, and visitors to review. 28 Pa. Code 201.14 (a) Responsibility of licensee

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 43923 Based on observation, and staff interview, it was determined that the facility failed to maintain the confidentiality of residents' medical information on one of three nursing units (Unit A Medication Cart). Findings include: During an observation on August 26, 2024, at 12:50 p.m. the Infection Preventionist, Employee E3 confirmed Medication Cart that was assigned to license nurse, Employee E5 which revealed to be left unattended with the computer screen open with identifiable information any passerby could see resident personal and confidential information. Employee E3 was not in the hallway nor near her medication cart. During an observation on August 26, 2024, at 2:25 p.m. the license wound nurse, Employee E8 confirmed Medication Cart that was assigned to license nurse, Employee E5 which revealed to be left unattended with the computer screen open with identifiable information any passerby could see resident personal and confidential information. Employee E5 was not in the hallway nor near her medication cart. On August 29, 2024, at 11:44 a.m. an Administrator, Employee E1 confirmed observation on A wing that Medication Cart which was assigned to registered nurse, Employee E13 revealed to be left unattended with the computer screen open with identifiable information any passerby could see resident personal and confidential information. Employee E13 was not in the hallway or nearby. During an interview on August 29, 2024, at approximately 2:30 p.m. the Nursing Home Administrator confirmed that the facility failed to maintain the confidentiality of residents' medical information as required. 28 Pa Code 211.5(b) Medical records

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06525 Based on review of clinical record, review of policy and procedure, and interviews with staff and residents, it was determined that the facility failed to investigate an allegation of possible abuse and neglect and report to the State survey agency the result of the investigation for one of 26 clinical records reviewed. (Resident R44) Findings include: Review of Resident R44's clinical record revealed that the resident was admitted to the facility on [DATE], with the diagnoses of schizophrenia (mental disease characterized by loss of reality contact), major depression, muscle spasticity, low back pain with sciatica (pain going from the lower back down the leg), IV (intravenous) drug abuse. Review of Resident R44's February 2024 physician orders revealed that the resident was ordered May 3, 2023, the pain/ narcotic medication Oxycodone 5 milligrams (mg) by mouth five times a day for severe pain and on May 5, 2023 Baclofen 10 mg by mouth ever six hours as needed for muscle spasms. Clinical record review revealed that on February 9, 2024 the nursing note indicated that Resident R44 was found unresponsive to verbal and painful stimuli. The staff attempted to arouse Resident R44 several times with no positive effect. The physician was contacted and ordered the staff to administer Naloxone nasally 4mg. After administration of the naloxone the nursing staff documented that the resident was aroused but had slurred speech and was unaware of time of place. The physician then ordered the nursing staff to send the resident to the hospital emergency room . Hospital record review revealed that on February 9, 2024 Resident R44 was examined by the emergency room physician who documented that Resident R44 had oxycodone and baclofen use and had an unintentional overdose with these medications. The physician had documented that Resident R44 had experienced hypercapnic respiratory failure and unintentional overdose or polypharmacy. Upon interview Resident R44 told the hospital examining physician that he was given oxycodone and Baclofen at the same time causing him to become unresponsive. Resident R44 reported to the hospital physician that he took two doses of baclofen incidentally with oxycodone and then went to sleep. Clinical record review on February 12, 2024 for Resident R44 revealed the diagnosis of poisoning by unspecified drugs, medications and biological substances. Clinical record review for Resident R44 revealed a psychiatry assessment on July 29, 2024 that indicated Resident R44 had diagnoses of depression and schizophrenia. The psychiatrist indicated that Resident R44 was alert and oriented and reporting that nursing staff may have given him too much narcotics because he was diagnosed with medication poisoning at the hospital, last time he was there. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with licensed nursing staff, Employee E15 at 10:00 a.m., on August 29, 2024 revealed that Resident R44 was found unarousable between 9:00 a.m., and 10:00 a.m., on February 9, 2024. The licensed practical nurse, Employee E15 also said that the physician ordered the administration of naloxone HCL nasal spray to be administered to Resident R44 for medication overdose on February 9, 2024. Employee E15 documented neurological checks as low blood pressure 81/53 and low pulse 56 for Resident R44 on February 9, 2024. The licensed nurse, Employee E15 reported that she called for emergency transport to the hospital for Resident R44 on February 9, 2024 as directed by the physician. Further interview with Employee E15 at 10:30 a.m., on August 29, confirmed that Resident R44 left the facility unescorted by staff for a cardiology appointment on January 16, 2024 and February 29, 2024. Interview with the Nursing Home Administrator and Director of Nursing at 10:00 a.m., on August 28, 2024 confirmed that there was no investigation into a case of possible neglect for Resident R44; who was found diagnosed at the hospital with unintentional overdose. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(d)(4)(e)(1) Management 28 Pa. Code 211.12(c)(d)(1) Nursing services

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923 Based on clinical record review and staff interviews, it was determined the facility failed to develop person-centered care plans related to elopement for one out of 26 residents sampled (Resident 78). Findings include: A review of the clinical record revealed Resident 78 was admitted to the facility on [DATE], with diagnoses of depression, anxiety disorder, recurrent, borderline personality disorder, narcissistic personality disorder. A review of a physician order, initially dated August 21, 2024 revealed the resident had a wanderguard (device that is place on ankle or wrist that activate the locking mechanism on doors to the outside of the facility) to back/right armrest of W/C (wheelchair). A review of progress notes dated, August 21, 2024, written by the license nurse, Employee E16 revealed resident continuously refused to take her meds. Resident has an increase aggression physically and verbally to staff. Resident was screaming/yelling/swinging at staff. Resident is at risk for elopement, stated I'm going to get out of here, and I'm not going back to this place and tends to stay by the exit door. A review of the current resident's plan of care revealed the resident's care plan failed to identify the resident's is an elopement risk and interventions develop on the resident's care plan to prevent elopment. An interview with the Resident R78 on August 26, 2024, at 10:54 a.m. revealed that she doesn't like the wander guard on the back right side of her armrest of the wheelchair and yesterday she cut it off with a butter knife. License Nurse, Employee E4 confirmed that the Resident's R78's wheelchair did not have a wander guard. Interview with the Director of Nursing on August 29, 2024, at approximately 1:30 p.m. confirmed the facility failed to ensure that comprehensive care plans were developed. 28 Pa. Code 211.12 (d)(5) Nursing services

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923 Based on clinical record review, observations, and staff interviews, it was determined that the facility failed to ensure that residents receive proper treatment and assistive devices to maintain hearing and vision abilities for one of 26 residents reviewed (Resident R32). Findings include: Review of the clinical record indicated that Resident R32 was admitted to the facility on [DATE], with diagnoses to include anxiety disorder, major depressive disorder, rheumatoid arthritis (chronic autoimmune disorder which effects joints, causing inflammation, pain and swelling), osteoporosis (bones loose density, making them thinner and less durable). A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident R32, dated, July 18, 2024 revealed that the resident was cognitively intact. Review of Resident R32's inhouse new Audiology summary dated January 25, 2024, indicated a recommendation for the Resident R32 for in office visit for myringotomy treatment (a surgery performed by an ear, nose, and throat (ENT) specialist to drain fluid from your middle ear). A follow ENT was conducted inhouse on June 26, 2024, for Resident R32 recommending the same treatment as it was not completed. On July 23, 2024, another hearing assessment report was conducting Resident's R32 hearing decreased; however, there was no documentation that Resident R32 was taken for the myringotomy treatment. Further review of the clinical record for Resident R32 revealed a vision consultation occurred on June 18, 2024 with a recommendation of bilateral cataracts surgery for left eye. An interview was held with the Resident R32 on August 26, 2024, at 1:57 p.m. that she unable to hear and reported I want to know about my hearing appointment, also it's been months for me to get cataract surgery. I had an appointment but did not go because there was no one who could go with me. Surveyor had to speak closely to Resident's R32's ear as Resident R32 was unable to hear. License nurse, Employee E24 who came in to administered medication confirmed that Resident R32 was unable to hear. On August 28, 2024, approximately 11:30 a.m. Director of Nursing, Employee E2 brought in Audiology summary assessment and reported that an appointment has been scheduled for September 5, 2024, by the medical record, Employee E11 for resident to go for myringotomy appointment and another appointment was scheduled for the resident to get her cataracts treatment for her vision on September 16, 2024. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the medical record, Employee E11 on August 28, 2024, at 1:25 p.m. who reported that it's her responsibility to schedule appointments and she was not aware of the need for myringotomy treatment and scheduled her an appointment on August 27, 2024 when surveyor questioned the recommendation. The protocol she would get a communication request from the unit manager to schedule an appointment for residents and then she calls to schedule. In this case she received a request for the myringotomy appointment request yesterday on August 27, 2024 from the unit manager. It was further revealed by Employee E11 who confirmed that an early cataract appointment was schedule for July 29, 2024, at 7:15 a.m.; however, due to staffing shortage there was no available staff to accompany the resident and it was canceled. It was further communicated that even transportation showed up at 7:15 a.m. However, there was no staff to accompany the resident. It was rescheduled for September 16, 2024. On August 29, 2024, at 8:51 a.m., an interview was conducted with the unit manager, Employee E15, who was responsible for communicating the need for appointments to the medical record staff. Employee E15 confirmed that Resident R32 had originally received a recommendation on January 26, 2024, for myringotomy treatment; however, the appointment was not scheduled until August 27, 2024, following an inquiry by the surveyor. Employee E15 was also unaware that Resident R32's cataract appointment had been canceled by the facility due to a staffing shortage. 28 Pa. Code 211.10(a)(c)(d) Resident care policies. 28 Pa. Code 211.12(d)(3) Nursing services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923 Based on review of facility policy, facility documentation, review of clinical records, observations, and staff interviews, it was determined that the facility failed to appropriately determine the effectiveness of interventions for a resident who was assessed as an elopement risk for one of the 26 residents reviewed (Resident R78) Findings include: A review of the facility policy titled Elopement Risk Evaluation Policy revised 12/12 revealed It is the policy of the facility that all residents will be evaluated upon admission, re-admission quarterly and with any changed in the resident's status to assess their risk for elopement. The Elopement Risk Evaluation will be reviewed and completed. Under procedure number 4. Interventions will be developed and implemented by the interdisciplinary Care Plan Team. The Interdisciplinary Team will re-evaluate interventions with each Elopement Risk Evaluation care conference and with any change in the resident's status. A review of the clinical record revealed Resident 78 was admitted to the facility on [DATE], with diagnoses of depression, anxiety disorder, borderline personality disorder, and narcissistic personality disorder. Review of Quarterly Minimum Data Set (MDS-a periodic assessment of care needs) dated August 22, 2024, indicated that the Brief Interview for Mental Status (BIMS) score of 14-cognition intact. A review of a physician order, initially dated August 21, 2024 revealed the resident had a wander guard (device that is place on ankle or wrist that activate the locking mechanism on doors to the outside of the facility) to back/right armrest of W/C (wheelchair). A review of Resident R78's clinical record did not indicate an Elopement Risk Evaluation was completed. A review of progress notes dated, August 21, 2024, written by the license nurse, Employee E16 revealed resident continuously refused to take her meds. Resident has an increase aggression physically and verbally to staff. Resident was screaming/yelling/swinging at staff. Resident is at risk for elopement, stated I'm going to get out of here, and I'm not going back to this place and tends to stay by the exit door. An interview with the Resident R78 on August 26, 2024, at 10:54 revealed that she doesn't like the wander guard on the back right side of her armrest of the wheelchair and yesterday she cut it off with a butter knife. License Nurse, Employee E4 confirmed that the Resident's R78's wheelchair did not have a wander guard. On August 29, 2024, at 1:34 p.m. with the license nurse, Employee E13 confirmed that for Resident R78's wheelchair does not have a wander guard and the resident unwilling to place the wander guard on Resident R78's wheelchair. It was confirmed that intervention to prevent elopment was ineffective. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On August 29, 2024, at 1:52 p.m. an interview with the unit manager, Employee E15 confirmed there was no other interventions explored by the facility besides the wander guard. Employee E15 confirmed that wander guard intervention was ineffective, and she has removed the physician order. An elopement assessment was requested to see if facility evaluated the significant risk for the resident for elopement. On August 30, 2024, at 2:00 p.m. Director of Nursing, Employee provided a Quarterly Evaluation which was created on August 21, 2024, documented that\ Resident R78 had an attempt in the last 30 days to elope and at risk to elope. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923 Based on clinical record review, observations, and staff interviews, it was determined that the facility failed to provide appropriate tracheostomy care for one of 26 residents (Resident R71). Findings include: Review of the clinical record indicated that Resident R71 was admitted to the facility on [DATE], with a diagnosis of encounter for attention to tracheostomy (a surgically created opening in the neck that allows direct access to the trache for breathing), chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs), acute respiratory failure hypoxia (is an emergency where the lungs are unable to supply enough oxygen to the blood, leading to dangerously low oxygen level (hypoxia). A review of Resident R71's Quarterly Minimum Data Set (MDS), a periodic assessment of care needs, dated July 21, 2024, showed that the Brief Interview for Mental Status (BIMS), which assesses cognitive function, returned a score of unknown, indicating that the resident's cognitive status could not be assessed at that time. On August 26, 2024, at 1:12 p.m., an observation was conducted with Infection Preventionist Employee E3 in Resident R71's room to assess tracheostomy supplies. Based on the physician's order dated April 25, 2024, Resident R71 was to have the following supplies at the bedside: Ambu bag, syringe, spare trach tubes (same trach size/type 6 and smaller trach size/type 4), and water-based lubricant. During the observation, it was confirmed that the required size 6 trach tube was not present at the bedside. Employee E3 then checked the medication cart, but the size 6 trach tube was not available there either. On August 26, 2024, at approximately 2:05 p.m., a surveyor observed a family member repeatedly entering and exiting Resident R71's room, requesting to speak with the assigned licensed nurse, Employee E5. When the surveyor approached the family member for an interview, it was revealed that Resident R71 had taken a shower earlier that morning, and the trach collar had not been changed, leaving it wet. The surveyor inquired how the family member knew the collar was wet and needed to be changed. The resident's faily memeber confirmed this by touching the collar and stating it was soaking wet and should have been changed after the shower. Family member further reported that a license nurse who was providing care it's not her regular nurse and most likely forgot to change her trach collar after a shower was given. The surveyor then went to the nursing station to locate Employee E5, only to be informed that Employee E5 was on a break outside the building. At 2:46 p.m., same day Employee E5 returned to change the collar. On August 29, 2024, at 11:45 a.m., licensed nurse Employee E12 was observed performing a tracheostomy treatment on Resident R71, which included changing the resident's trach collar. During the procedure, Resident R71 required suctioning; however, Employee E12 did not have a disposable inner cannula readily available, either at the bedside or in the medication cart. Another licensed nurse, Employee E17, had to retrieve the cannula from the medication storage room. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On August 29, 2024, at approximately 2:30 p.m., these observations were confirmed by Infection Preventionist Employee E3 and Director of Nursing Employee E2. 28 Pa. Code: 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923 Based on review of staffing schedules, facility documentation, and staff interview, it was determined that the facility failed to ensure sufficient nursing staff to assure residents attain or maintain the highest practicable physical, mental, and psychosocial well-being for 3 of 26 residents reviewed (Residents R78, R100, R32). Findings include: A review of the clinical record revealed Resident 78 was admitted to the facility on [DATE]. Review of Quarterly Minimum Data Set (MDS-a periodic assessment of care needs) dated August 222, 2024, indicated that the Brief Interview for Mental Status (BIMS) score of 14-cognition intact On August 26, 2024, at 10:40 a.m., an interview was conducted with Resident R78, who expressed feeling very upset and began crying. Resident R78 stated, They don't answer the call bell and make me wait for an hour to be changed. The last time I was changed was at 6:00 a.m. this morning. The surveyor asked her to press the call bell, but it was not functioning, as the indicator light did not turn on. The surveyor then approached licensed nurse, Employee E4, who was distributing medications outside the door. Employee E4 confirmed that the call bell was indeed not working. When asked if the resident had received her morning care, Employee E4 responded, No, explaining that they were short-staffed. The A wing has 44 residents, but only three nursing assistants and two nurses to cover the area. Some residents require the assistance of two staff members or the use of lifts. Employee E4 further confirmed that Resident R78, who is incontinent, was wet and required assistance with Activities of Daily Living (ADL). On August 26, 2024, at 12:15 p.m., observations were made in the main dining room, where approximately 10-12 residents were seated, waiting for lunch to be served. No staff members were present in the dining room at that time. At 12:29 p.m., the regional RN, Employee E25, was interviewed regarding supervision requirements in the dining area inthe company of the Assistance Nursing Home Administrator, Employee E1. It was reported that activity staff member or nursing personnel should always be present to oversee the dining room. The Assistance Nursing Home Administrator further stated that the Director of Nursing's (DON) office and the Administrator's office are located outside of the dining hall, allowing them to help if necessary. Review of the admission record indicated Resident R100 was admitted to the facility on [DATE]. Review of Quarterly Minimum Data Set (MDS-a periodic assessment of care needs) dated August 20, 2024, indicated that the Brief Interview for Mental Status (BIMS) score of 15-cognition intact. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On August 26, 2024, at 1:45 p.m., an interview was conducted with Resident R100, who reported receiving care at 5:30 a.m. that morning. He stated that he is typically placed in his wheelchair by 10:30 a.m. or 11:00 a.m., but on this day, Resident R100 was still in bed because no one had come to assist him into his wheelchair. Resident R100 pressed the call bell, and a nursing aide, Employee E25, responded. Employee E25 confirmed that they were behind schedule due to staffing shortages, noting that there were 44 residents and only three nursing aides. She also mentioned that she was responsible for 15 residents that day and give four showers. An assignment sheet was provided as evidence, confirming that Employee E25 was assigned to residents in rooms A6-1, A8-1, A8-2, A9-1, A9-2, A10-1, A10-2, A11-1, A11-2, A12-A, A12-2, A13-1, A13-2, A15-1, and A15-2. An interview was held with the Resident R32 on August 26, 2024, at 1:57 p.m. that she unable to hear and reported also it's been months for me to get cataract surgery. I had an appointment but did not go because there was no one who could go with me. On August 26, 2024, at 2:03 p.m. a nursing assistant, Employee E7 was interviewed and reported that she was assigned to 14 residents and was behind on providing care. On August 27, 2024, at approximately 8:00 a.m., there were no staff members present on the A wing when the surveyor approached the nursing station. All the nursing aides (Employee E7, and E21) assigned to the unit were observed having breakfast. When the surveyor inquired why the residents had not yet received their morning care, a licensed nurse Employee E15 responded that she had not yet completed the assignment sheet to allocate specific room coverage to the nursing aides. On August 27, 2024, at 10:36 a.m. a resident group meeting was held with nine alert and oriented residents (R75. R115, R83, R83, 51, R55, R34, R4, R99, R48) who reported that Sunday, August 25, 2024, a dining room was closed due to shortage of staffing. The facility one main dining room and residents were told due to shortage of staffing they had to eat lunch and dinner in their rooms. It was further revealed by medical record, Employee E11 who confirmed that Resident R32 had an early cataract appointment schedule for July 29, 2024, at 7:15 a.m.; however, due to staffing shortage there was no available staff to accompany the resident and it was canceled. It was further communicated that transportation showed up at 7:15 a.m. However, there was no staff to accompany the resident. It was rescheduled for September 16, 2024. 28 Pa Code 211.12 (d)(4) Nursing services 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(1)(3) Management

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395110	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Healthcare & Rehabilitation Center	2109 Red Lion Road Philadelphia, PA 19115

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 46993 Based on review of facility provided documentation, and review of clinical record, it was determined that the facility did not ensure to have attending physician address and document pharmacist's identified irregularities for one of 26 residents reviewed (Resident R127) Findings include: Review of facility provided policy 'Pharmacy Consultant Recommendations,' revised December 16 (unknown year), indicates that the attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. Review of R127's clinical record on August 29, 2024 at 12:00 PM, revealed Resident R127 was admitted to facility July 26, 2024 with BIMS (Brief Interview of Mental Status) score of 5, which indicated that the resident was cognitively impaired. The resident's diagnoses included of depression, subsequent encounter of falls, muscle wasting and atrophy, dementia with mood disturbance, difficulty swallowing, difficulty walking, transient ischemic attack (stroke), anemia, vitamin D deficiency. Further review of Resident R127's clinical record revealed an active order for Trazadone HCL oral tablet 50 mg on August 5, 2024 at 10:47 AM, to give 25 mg (milligrams) by mouth every 12 hours as needed for anxiety/insomnia. Review of Resident R127's pharmacy review 'comments report' dated August 12, 2024, completed by pharmacist - Employee E9, states that a duration must be specified for as needed (PRN) psychoactive medications. First order is limited to only 14 days, but if rationale documented by prescriber to continue order, then next duration may be for longer, i.e. 30, 60, or 90 days. Please update order for trazadone per CMS regulations. Further review of Resident R127's clinical record revealed no evidence of whether the attending physician identifying the need for and continuing use of Trazadone medication identifying and addressing adverse consequences related to medication. 28 Pa Code 211.2(a)Physician Services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923 Based upon review of facility policy and procedure, observation, and clinical record review, it was determined the facility failed to establish Enhanced Barrier Precautions for three of 26 residents observed (Resident 71, Resident 4, and Resident 63) Findings include: Review of facility policy and procedure titled Enhanced Barrier Precaution (EBP) revealed All applicable employee to adhere to Enhanced Barrier Precautions, per guidelines. Under Process: A physician order for enhanced barrier precautions is entered in the EHR. The order will contain the a reason for the EBP. EBP will be Care Planned and tasked out to the Care Kardex. An Enhanced Barrier Precautions sign will be posted on the door/outside of the room, of Residents that required Enhanced Barrier Precautions. A red Dot (Sticker) will be placed on the affected Resident's door tag to indicate which Resident requires Enhanced Barrier Precautions. The Unit Manger is responsible for: Updating and completion of the Enhanced Barrier Precautions log, Providing the IP or designee an updated EBP log weekly, Enhanced Barrier Precautions signage on the door, A red Dot (Sticker)placed on the affected Resident's door tag. Unit round audits checking for: Proper Signage/Dots, Staff adherence to precautions. On August 26, 2024, at 12:33 p.m., Resident R4, located in room A22-1, was observed receiving wound treatment from licensed nurse Employee E5 while in bed. During the procedure, Employee E5 did not utilize Enhanced Barrier Precautions (EBP) as required. After exiting the room, Employee E5 confirmed that she had provided wound care to Resident R4's knee without using EBP. A review of Resident R4's clinical record, including a physician's order dated May 15, 2024, indicated that the resident was to Maintain Transmission-Based Precautions: Enhanced Barrier Precautions due to MRSA bacteremia in the blood and a right knee sinus tract, as well as MSSA in a bone/joint wound. Additionally, it was noted that Resident R4's door sign did not have a red dot, as per facility policy, which would have alerted staff to the need for EBP. On August 26, 2024, at 12:39 p.m., licensed nurse Employee E5 provided wound treatment to Resident R63, residing in room A22-2, for a sacral wound without using Enhanced Barrier Precautions (EBP). After completing the treatment, Employee E5 exited the privacy curtain and requested assistance from nursing assistant Employee E25 to help reposition Resident R63, again without applying EBP. Following the procedure, an interview was conducted with Employee E5, who reported that she was unaware that EBP was required. It was noted that Resident R63's door had a red dot sign, indicating to staff that EBP should have been used during care and treatment. On August 26, 2024, at 12:50 p.m., an interview was conducted with Infection Preventionist Employee E3, who explained that a red dot on a resident's outside door sign indicates that Enhanced Barrier Precautions (EBP) are required when providing care or wound treatment. It was confirmed that both Residents R4 and R63 should have red dots on their door signs. However, during the interview, it was observed that Resident R4's sign did not have a red dot to communicate the need for EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the interview, licensed nurse Employee E5 was asked about her understanding of the red dot's meaning, and she reported that she was unaware of its significance. Employee E11 was then retrained on the meaning of the red dot and the implementation of EBP. Review of the clinical record indicated that Resident R71 was admitted to the facility on [DATE], with a diagnosis of encounter for attention to tracheostomy (a surgically created opening in the neck that allows direct access to the trache for breathing). On August 29, 2024, at 11:45 a.m., licensed nurse Employee E11 was observed performing a tracheostomy treatment on Resident R71, which involved changing the resident's trach collar without following Enhanced Barrier Precautions (EBP). These precautions are required for all tracheostomy treatments to ensure proper infection control and safety. On August 29, 2024, at approximately 2:30 p.m., Infection Preventionist Employee E3 confirmed that all tracheostomy treatments for Resident R71 require the use of Enhanced Barrier Precautions (EBP) when providing care or treatment. 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.12(c)(d)(1)(2)(3)(5) Nursing Services