STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395135	A. Building B. Wing	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pennypack Nursing and Rehabilitation Center	8015 Lawndale Avenue Philadelphia, PA 19111

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39343 Based on review of clinical records, facility documentation, and interviews with staff, it was determined that the facility failed to issue the resident/resident representative a Notice of Medicare Non-Coverage (NOMNC) prior to termination of Medicare A services, as required, for one of three residents' records reviewed (Resident R25). Findings include: Review of Facility policy on Medicare Advance Beneficiary and Medicare Non-coverage Notices, indicated that if the resident's Medicare covered Part A stay or when all of Part B therapies are ending, a Notice of Medicare Non-coverage (CMS form 10123) is issued to the resident at least two calendar days before benefits end. Review of the clinical record for Resident R25 revealed that the resident was admitted to the facility on [DATE], with Medicare insurance coverage for skilled nursing care. Further review of the record revealed that Resident R25's Last Covered Day of Part A Service was June 28, 2024. Review of clinical records revealed that the Notice of Medicare Non-Coverage (NOMNC - written notice to the resident, beneficiary, or resident representative, of the right to an expedited review of a Medicare service termination) was issued to Resident R25 or the resident's representative only on July 17, 2024. Interview with the Nursing Home Administrator on August 26, 2018, at 12:30 p.m., confirmed that the facility failed to issue a Notice of Medicare Non-Coverage (NOMNC) to Resident R25 prior to the termination of the Medicare A service. The facility failed to issue a Notice of Medicare Non-Coverage (NOMNC) prior to termination of Medicare A services, as required. 28 Pa. Code 201.29(f) Resident rights

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395135	A. Building B. Wing	08/26/2024

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609 Based on clinical record review and staff interview, it was determined that the facility failed to notify the representative of the Office of the State Long Term Care Ombudsman for two of 16 resident records reviewed (Residents R2, R36). Finding include: Review of Resident R2's clinical record revealed that the resident was admitted to the facility on [DATE], diagnosed with neuromuscular dysfunction of the blader and infection and inflammatory reaction due to indwelling urethral catheter. Review of Resident R2's nursing progress note dated May 21, 2024, revealed the resident was transferred to the hospital when there was a complaint of severe abdominal pain and blood noted in urine. Further review of the resident's record revealed the resident was transferred to the hospital on June 6, 2024, due to acute kidney failure. Resident R36 was admitted to the facility on [DATE], for aftercare following a joint replacement. Review of Resident R36's nursing progress notes dated July 13, 8 and 7, 2024 indicated the resident was transferred to the hospital due to a change in condition. Interview on August 23, 2024, at 2:00 p.m. the Nursing [NAME] Administrator confirmed that there were no written notices of the hospital transfers given to the State Long Term Care Ombudsman upon transfer out of the facility for Resident R2, and Resident R36. . 28 Pa. Code 201.29(h) Resident rights

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	395135	A. Building B. Wing	08/26/2024

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39343 Based on clinical record review and staff interview, it was determined that the PASRR (Preadmission Screening and Resident Review) was not appropriately completed for one of 24 residents reviewed (Resident R16). Findings include: The PASRR (Preadmission Screening Resident Review) was created in 1987 through language in the Omnibus Budget Reconciliation Act (OBRA) and it has three goals: to identify individuals with mental illness and/or intellectual disability, to ensure they are placed appropriately, whether in the community or in a nursing facility, and to ensure they receive the services they require for their mental illness or intellectual disability. The PASRR Level 1 must be completed on all persons who are considering admission to a Medicaid certified nursing facility. Review of Resident R16's clinical record revealed the resident was admitted to the facility on [DATE], with a diagnosis to include Major Depressive Disorder (A mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), Post-Traumatic Stress Disorder (A disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), Schizoaffective Disorder (Schizoaffective disorder is a combination of symptoms of schizophrenia and mood disorder, such as depression or bipolar disorder), and Anxiety Disorder (A mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). Review of Resident R16's clinical record revealed a Pennsylvania Preadmission Screening Resident Review Identification Level I Form (PASRR) which indicated; for section VIII- PASRR LEVEL I Screening Outcome, the resident was not checked off for the outcomes that may or may not lead to chronic disability. Interview on August 26, 2024, at 11:30 a.m., with the Director of Nursing, confirmed the finding. 28 Pa Code 211.5(f) Clinical records 28 Pa Code 211.16(a) Social services

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	395135	A. Building B. Wing	08/26/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 39343 Based on observations, clinical record review, review of facility documents and staff interviews, it was determined that the facility failed to revise the care plan for fall prevention, for one of 24 residents reviewed (Resident R25). Findings include: Review of Resident R25's clinical record revealed that the Resident was admitted in the facility on April 10, 2019. R25's diagnoses included, Unspecified Dementia (Dementia is a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), Anxiety Disorder (A mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), Unspecified Glaucoma (A condition in which there is a build-up of fluid in the eye, which presses on the retina and the optic nerve. The retina is the layer of nerve tissue inside the eye that senses light and sends images along the optic nerve to the brain. Glaucoma can damage the optic nerve and cause loss of vision or blindness), Muscle Wasting and Atrophy (Muscular Atrophy is the decrease in size and wasting of muscle tissue), Unspecified Lack of Coordination (Lack of Coordination can be due to damage to brain, nerves, or muscles). Review of Clinical Nursing Progress Note, dated April 3, 2024, for R25, indicated that Resident fell at about 11:35 a.m., outside of another resident's room, resident found lying on her left side, it was observed during assessment that resident had hematoma on left-side of forehead, and per physician-order Resident R25 was sent to the hospital for evaluation and treatment. Resident R25 was readmitted from the hospital on April 8, 2024. Further review of clinical progress notes dated April 8, 2024, indicated the Fall Risk Evaluation for Resident R25, resulted in Fall Risk Score of 21.0. Review of the care plan for Resident R25, indicated that the resident's fall- prevention- care plan, initiated on January 5, 2023, with the target date of April 2, 2024, was not updated, or revised, to reflect the interventional status, based on the fall risk evaluation or the fall occurred on April 3, 2024. On August 26, 2024, at 1:17 p.m., the Director of Nursing, confirmed that the findings regarding the lack of revision and updating of the care plan for Resident R25, related with the fall was accurate. 28 Pa Code 211.5(f) Clinical records 28 Pa Code 211.11(d) Resident Care Plan 28 Pa Code 211.12(c)(d)(3) Nursing services 28 Pa Code 211.12(d)(1)(5) Nursing services

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	395135	A. Building B. Wing	08/26/2024

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609 Based on observation, review of resident's records, facility's policies and interviews with staff, it was determined that the facility failed to ensure adequate pain management was provided for one resident documented with severe pain of 16 resident records reviewed (Resident R38). Findings include: Review of the facility's policy for Pain Assessment and Management revised on October 2022, states that pain management is a process that includes assessing the resident for potential pain, recognizing the presence of pain, developing and implementing interventions for pain, monitoring the resident to determine if the resident's pain is being adequately controlled, and to assess the effectiveness of the resident's level of comfort overtime. The same policy states to contact the physician immediately if the resident's pain or medication are not adequately controlled. Review of Resident R38's clinical record revealed an initial admitted [DATE] diagnosed with a cerebral infarction (stroke), and following the stroke diagnosed with Aphasia (inability to understand or express speech) and dysphagia (swallowing difficulties) with severe malnutrition (lack of proper nutrition), In addition the resident was diagnosed with Parkinson's disease (a progressive nervous system disorder), bipolar (a mental disorder that causes extreme mood swings) dementia (loss of intellectual function), bilateral knee contractures, multiple pressure ulcers, osteomyelitis (bone infection from the pressure ulcers), urethral fistula (a tunnel that connects to the genital area, causing urine to enter the rectum, and feces to enter the bladder) and used a gastrostomy (a surgical feeding tube place through the skin into the stomach allowing direct access of fluids and nutrients). Review of Resident R38's admission MDS (Minimum Data Set, an assessment of resident's needs) dated May 5, 2024, assessed the resident as severely, cognitively impaired, with physical impairments to both sides of the upper and lower body, and was incontinent of bowel and bladder. The resident was assessed as completely dependent on staff for bed mobility, transfers, personal hygiene, toileting and bathing, The same MDS indicated the resident was on a scheduled pain medication regimen, receiving pain medication when needed, noting the resident did not receive non-medication interventions for pain. The resident was assessed with one (1), Stage III pressure ulcer (full thickness tissue loss, subcutaneous fat may be visible, slough may be present but does not obscure the depth of the tissue loss that may include undermining and tunneling) and two (2) Stage IV Pressure Ulcers (full thickness tissue loss with exposed bone, tendon, or muscle, slough or eschar may be present and often includes undermining and tunneling, and five unstageable pressure ulcers (depth unknown due to the wounds covered by slough and/or eschar). On August 20, 2024, at 12:00 p.m. Resident R38 was observed in bed with her eyes closed not acknowledging the presence of the surveyor when name was repeatedly called. On August 23, 2024, at 10:00 a.m. the surveyor observed the resident in bed with her eyes closed. The resident did not respond when the surveyor called out her name. When surveyor asked if she had pain, the resident's eyes opened looking in the direction of the surveyor unable to verbalize her needs. (continued on next page)

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	395135	A. Building B. Wing	08/26/2024

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R38's physician orders revealed an order for Tramadol 50 mg starting on May 1, 2024, until August 2, 2024, that instructed to give a half a tablet every eight hours for pain (the severity or type of pain was not specified) and to indicate the level of pain 0 to 10 (10 being the worst pain). Review of Resident R38's care plan for pain management dated May 6, 2024 included intervention to monitor/record/report any signs and symptoms of non-verbal pain and to report these occurrences to the physician. Resident R38's pain assessment dated [DATE], indicated the resident's pain, Frequently limited the resident's participation in rehabilitation, the pain Almost constantly limited the resident's day to day activities, the pain intensity was assessed at a 9 with the resident's verbal descriptor scale as severe, with indicators of pain that included non-verbal sounds, verbal complaints of pain, and facial expressions of pain. The pain location was documented at the resident's left hip, right hip, coccyx, right elbow, left and right heel, Review of Resident R38's electronic medication administration record (EMAR) during the time the pain medication was given for the months of May, June, and July, 2024 revealed the resident was documented as frequently experiencing very strong, to the worst pain possible (8-10). Further review of the MAR for May, June, and July 2024 revealed no evidence of further assessments or appropriate monitoring for the effectiveness of the pain medication once it was administered. Interview with the Regional Registered Nurse Employee E8 and Licensed Registered Nurse Employee R7 on August 23, 2024, at 10:30 a.m. stated on August 2, 2024 the resident was experiencing pain on night shift and the resident's pain regimen changed to Percocet (a medication for pain) given as needed. The facility could not show evidence prior to this change that they responded appropriately when documentation revealed Resident R38's was experiencing severe pain. 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(2) Nursing services 28 Pa. Code 211.12(d)(3) Nursing services

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	395135	A. Building B. Wing	08/26/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 39343 Based on observations, review of clinical records, and interviews with facility staff, it was determined that the facility failed to ensure that it was free of medication error rate of five percent or greater for three of four residents observed during medication administration (Resident R31, R48, and R49). Findings include: On August 21, 2024, 9:02 a.m., observed that Employee E3, a Licensed Nurse, administered to Resident R49, the medicine, Aspirin 81 mg, Chewable tablet, one tablet by mouth; when asked the Licensed Nurse to double check the medicine, the nurse stated it was Aspirin 81 mg, Chewable tablet. Review of physician order for Resident R49, dated August 17, 2024, revealed an order to administer Aspirin Enteric-Coated (EC) Tablet Delayed Release 81 MG (Aspirin), Give 1 tablet by mouth one time a day for Thrombocytosis. Review of literature revealed that Aspirin comes in enteric-coated and non-enteric (regular) forms. Regular Aspirin is absorbed in the stomach, while Enteric-Coated aspirin is absorbed in the small intestine. At the time of the observation, interview with Licensed nurse Employee E3, confirmed the above findings. On August 21, 2024, 9:16 a.m., observed that Employee E4, a Licensed Nurse, administered to Resident R31, the medicine Calcium with Vitamin D 600 mg/10 mcg (400 IU), by mouth. Review of physician order for Resident R31, dated February 28, 2022, revealed an order to administer Calcium-Vitamin D3 Tablet 500-400 MG-UNIT (Calcium Carb-Cholecalciferol), Give 1 tablet by mouth two times a day for Supplement With breakfast and lunch. At the time of the observation, interview with Licensed nurse Employee E4, confirmed the above findings. Review of physician order for Resident R48, dated August 8, 2024, revealed an order to administer Senna Oral Tablet 8.6 MG (Sennosides), Give 1 tablet by mouth in the morning for constipation. On August 21, 2024, 9:32 a.m., observed that Employee E4, a Licensed Nurse, was going to administer to Resident R48, the medicine named Senna Plus tablet, by mouth, but was prevented the administration of Senna Plus tablet. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of literature indicated that Senna Plus is used to treat constipation. It contains two medications: Sennosides and docusate. Sennosides are known as stimulant laxatives. They work by keeping water in the intestines, which helps to cause movement of the intestines. Docusate is known as a stool softener. It helps increase the amount of water in the stool, making it softer and easier to pass. Review of literature specified that Sennosides are known as stimulant laxatives. They work by keeping water in the intestines, which causes movement of the intestines. At the time of the observation, interview with Licensed nurse Employee E4, confirmed the above findings. The facility incurred a medication error rate of 11.54%. Pa Code:211.12(d)(1)(2)(5) Nursing Services.

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	395135	A. Building B. Wing	08/26/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 39343 Based on observation, review of facility policy and procedures and interview with staff, it was determined that the facility failed to maintain an effective infection control program related to the transportation, sorting, washing, and drying of soiled resident clothing and the storage of clean linens and residents' clothing in the laundry room. Findings include: Review of facility Policy on Infection prevention and control program revealed that infection prevention and control program (IPCP) was established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Review of facility document entitled Clean Linen Storage and Handling revealed; sort, transport, and store clean linens in a manner that prevents risk of contamination by dust, debris, soiled linens, or other soiled items. Observation on August 20, 2024 at 10:20 AM in the presence of the Food Service Director and the Director of Housekeeping revealed that the facility's outside dumpster area contained large blue containers filled with dirty hospital gowns. The Director of Housekeeping indicated the facility used a laundry service and the gowns were waiting to be picked up tomorrow for their services. Observation of the laundry room located in the basement conducted on August 26, 2024, at 10:48 a.m. revealed that the basement was accessible from inside the facility through a door leading to a wooden staircase, which was covered with dust and particles of stains. Further observation revealed that to reach the laundry room, used for the laundry service of the personal clothing of the residents, multiple congested areas, filled with various obsolete- looking pieces of gadgets had to be walked behind, and there was only one door to the laundry area. The laundry room measured approximately 18 x 15 feet in size. In the laundry room, there were three dryers (non-commercial). There were two washing machines (non-commercial) adjacent to the wall facing the door. On the corner of the room, near the entrance wall, and near the washing machines and the dryers, were a big pile of clear plastic bags of clothing on the floor reaching to the same height as the washing machines. Continued observation of the laundry area revealed that to the left of the room (left wall) was a desk with computer and printer, and further down the left wall was kept, housekeeping supplies, and tools seems like scrubbing pads for floor stripping machines, and mop heads. Further, observation of the Laundry room revealed that there was a large pile of sweeper mop cloths. Additional observation revealed that the floor of the Laundry room was dirty with black colored sticky particles, peeled paintings, rusted metal parts. Also observed that the laundry room was congested with gadgets like materials, clean and soiled items, personal clothes, and mop heads which were not sufficiently separated. Interview with Housekeeping staff, Employee E6 confirmed that the pile of sweeper mop cloths were items that had already been washed. (continued on next page)

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	395135	A. Building B. Wing	08/26/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the laundry room revealed that there were no clear designated area for soiled items, and clean items. Additionally, the congested space in which the soiled clothing and other soiled items were transported, delivered, sorted, washed, dried, folded and stored, did not allow for the prevention of contamination of the clean clothing by the soiled items. Observation of the shower room, located near the resident room B6, conducted on August 26, 2024, at 11:23 a.m., revealed that clean linens were stored in racks without doors, but with covering drapes. Further observation revealed that soiled lines were stored in the same shower room, in plastic bags. At the time of the finding, it was confirmed with the Housekeeping Director, Employee E6. Observation of the shower room, located near the resident room A10, conducted on August 26, 2024, at 11:33 a.m., revealed that clean linens were stored in racks without doors, but with covering drapes. Further observation revealed that soiled lines were stored in the same shower room, in plastic bags. At the time of the finding, it was confirmed with the Housekeeping Director, Employee E6. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(a)(3) Management