STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395338	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Immaculatemarycenter for Rehabilitation&healthcare	2990 Holme Avenue Philadelphia, PA 19136

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 38947 Based on observations, interviews and the review of clinical record, it was determined that the facility failed to ensure that 1 out of 37 residents was assessed to ensure that it was clinically appropriate to self-administer medication (Resident R606). Findings include: Review of the facility policy, Self-Administration of Medication, with an effective date of 11/2017 indicated that the resident's mental and physical abilities will be assessed to determine whether self-administering medication is clinically appropriate for them to do so, in addition to other assessment factors that include, but not limited to the resident's ability to read and understand medication labels, the resident's comprehension of the purpose, proper dosage, the administration time for the medication(s), and the resident's comprehension of the purpose and proper dosage and administration time for his or her medications. Continued review of the policy indicated that self-administered medications must be stored in a safe and secure place in the resident's room, in a medication cart, or in the facility's medication room. Review of the resident's June 2024 physician orders included the following diagnosis: aortic aneurism (a bulge in the wall of an individual's aorta that can rupture or dissect and cause life-threatening bleeding) hypertension (High blood pressure); epilepsy (a brain condition that causes recurring seizures) and glaucoma (a condition in which the nerves that provides information to the brain is damaged and will cause gradual vision loss if not treated). Review of the physician orders for June 2024 included a physician order dated February 26, 2024 for the medication eye drop, Combigan Solution 0.2-0.5% (Brimonidine-timolol-generic name). The physician's order included instructions for the resident to be administered 1 drop in both eyes every 12 hours for the treatment of glaucoma. There were no instructions in the physician orders for the resident to self-administer this medication. Continued review of the June 2024 included a physician's order dated March 13, 2024 for the medication eye drop, Xalatan Ophthalmic Solution 0.005% (Latanoprost-generic name). The physician's order included instructions for the resident to have one drop of the medication administered in both of her eyes in the evening for the treatment of glaucoma. The physician's order also indicated that the resident may self-administer this medication. (continued on next page)

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's person-centered plan of care included a plan of care for the treatment for the resident's glaucoma with a revision date of February 28, 2024 for the resident to demonstrate proper use of the self-administration of eye drops that can be kept at the resident's bedside. The eye drops documented in the plan for self-administration are Combigan. During an observation in the resident's room on June 17, 2024, at 10:15 a.m. Resident R606 was observed in her room in her wheelchair with a sandwich bag on her bed with what appeared to be at least 3 bottles of medication in it, amongst other things. The bottles of eye medications were labeled as being Comigan and Latanoprost (as described her June 2024 physician orders) were observed in the a zip lock sandwich bag. A 3rd eye medication, Systane (an over the count medication that relievers the symptoms of dry eyes) was also observed in the zip log sandwich bag. The resident's June 2024 physician orders did not show evidence of the medication, Systane, but during the above referenced interview with the resident, she reported that that she utilizes this medication to treat her dry eyes. When asked, the resident reported that the bottles of medication in her bag were her eye drops that she administers on her own. When asked resident if she keeps her medication in a locked drawer or if nursing staff keeps it for her until it is time for her to administer it to herself, she stated that she keeps it in her room on her table or where it is now (referring to her bed where the medication was located). Review of the resident's clinical record did not show evidence that an assessment was completed on the resident to ensure that it was clinically appropriate for the resident to self-administer the eye drops (e.g. the resident's ability to ensure that the medication is safely stored if she is going to keep them in her room, the resident's understanding of instructions regarding the administration of the medication, in addition to the resident's cognitive status related to the administration of the eye drops). During an interview with the unit manager (Employee E3) on June 17, 2024, at 11:32 a.m. it was confirmed that the resident does self-administers the eye drops on her own and that there was no evidence that an assessment done by the facility to ensure that it was clinically appropriate for the resident to do so. 28 Pa. Code 211.12 (d) Nursing services 28 Pa. Code 211.12(d)(1) Nursing services

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. 38947 Based on interviews and review of clinical records, it was determined that the facility failed to ensure that written notice, including the reason for the room change was provided to the resident and/his or her responsible party prior to the room change for 1 out of 37 residents reviewed (Resident R609). Findings include: Review of the facility's policy Room Changes, with a revision date of October 2022 indicated that when a resident request a room change, they will be offered another appropriate bed, as available. The policy also stated that before the room change occurs, the resident and their roommate will be notified of the reason for the room change. Review of the Resident R606's June 2024 physician orders included the following diagnosis: aortic aneurism (a bulge in the wall of an individual's aorta that can rupture or dissect and cause life-threatening bleeding), hypertension (high blood pressure); epilepsy (a brain condition that causes recurring seizures) and glaucoma (a condition in which the never that provides information to the brain is damaged and will cause gradual vision loss if not treated). Review of the November 2023 physician orders for Resident R609 revealed a nursing note at 10:53 p.m. indicated that she was admitted into the facility from a hospital on November 3, 2023. Review of the resident's physician orders for November 2023 included the following diagnosis: dysphagia (difficulty swallowing); respiratory failure (a condition that makes it difficult for an individual to breath on their own); dementia (a term used to describe a group of symptoms affecting an individual's memory, thinking and social abilities); anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome); hypertension (high blood pressure) and chronic obstructive pulmonary disease (COPD- a long-term lung disease that makes it difficult to breath). Review of Resident R609's Admission Minimum Data Set Assessment (MDS-period assessment of a resident's needs) dated November 9, 2023, indicated that the resident was cognitively impaired. Review of the nursing notes written in the clinical record of Resident R609's roommate (Resident R606) by Employee E9 (licensed nurse) dated December 12, 2023 at 3:47 a.m. during the 11:00 p.m. through the 7:00 a.m. shift, documented that Resident R606 came to the nursing station yelling that her roommate (Resident R609) should be taken out of the room because Resident R609 keeps talking to herself, and she (Resident R606) is unable to sleep. Continued review of the nurse note documented that Resident R606 stated to Employee E9 that if her roommate is not taken out of the room, she was going to strangle her. Continued review of the note indicated that Employee E9 notified the nursing supervisor of what Resident R606 stated, and Resident R609 was then moved to another room (410B) with the assistance of two staff during the above-referenced nursing shift. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record for Resident R609 did not show any documentation that the resident and/or her responsible party was sent written notice about the room change, and the reason why the room change was being required (e.g. why Resident R609 had to move from the room when it was her roommate who had the complaint) prior to the move that took place on the 11:00 p.m. through the 7:00 a.m. shift. to ensure that the resident and her responsible party had the opportunity to meet Resident R609's new roommate, see the new room location, and ask any questions that the resident and/or the responsible party may have had before the room change. During an interview with the 7:00 a.m. through 3:00 p.m. Unit Manager (Employee E3) on June 17, 204 at 11:32 a.m. it was confirmed that Employee E3 was notified of the room change that took place on December 12, 2023 on the previous shift (11:00 p.m. through the 7:00 a.m.) when she came in for her 7:00 a.m. through 3:00 p.m. nursing shift. Employee E3 reported that she verbally notified Resident R609's daughter on December 12, 2023, of her mother's room change that took place on the previous shift (11:00 p.m. through the 7:00 a.m.) and documented the telephone call with the resident's responsible party on the facility's Room/Roommate Change Sheet. 28 Pa. Code 201.14(a) Responsibility of licensee 29 Pa. Code 201.29(d) Resident rights

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 43277 Based on review of facility policy and review clinical records it was determined that the facility failed to ensure that the physician was notified of a resident's refusal to take prescribed medications for one of 46 residents reviewed (Resident R108). Findings Include: Review of the facility policy titled Administering Medications, effective March 2020, states medications shall be administered in a safe and timely manner, and as prescribed. Review of Resident R108's Quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated May 31, 2024, revealed the resident was cognitively intact, had a diagnosis of diabetes mellitus (characterized by high blood sugar levels in the blood - a disorder in which the body does not produce or appropriately utilize insulin in the body) and received insulin (hormone produced by the body which regulates the amount of glucose in the blood) injections. Review of Resident R108's comprehensive care plan revised October 6, 2022, revealed the resident had potential for hyperglycemia related to a diagnosis of diabetes, non-compliant with diabetic diet, and refusal of insulin. Interventions dated July 17, 2021, included to administer medication per order and report any concerns to the doctor. Review of Resident R108's physician orders revealed an order for Humalog (fast acting insulin that lowers blood sugars) injections subcutaneously (injection between the skin and muscle) before meals [3 times per day] dated February 23, 2024. Review of Resident R108's physician orders revealed an order for Levemir (long-acting insulin) injections subcutaneously at bedtime for diabetes mellitus. Review of Resident R108's medication administration record (MAR) for May 2024 revealed the resident refused 21 out of 31 prescribed doses of Levemir. Further review of Resident R108's MAR for May 2024, revealed the resident refused 58 out of 93 prescribed doses of Humalog. Review of Resident R108's MAR for June 2024 revealed the resident refused 10 out of 13 prescribed doses of Levemir. Further review of Resident R108's MAR for June 2024, revealed the resident refused 24 out of 39 prescribed doses of Humalog. Review of Resident R108's entire clinical record revealed no documented evidence the physician was made aware of the frequent refusals of the prescribed insulin. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R108's clinical record revealed assessments by Physician, Employee E18, dated June 3, 2024, and June 11, 2024, that the diabetes weas treated with Levemir and Humalog. Further review of Resident R108's clinical record revealed an assessment by Nurse Practitioner, Employee E17, dated June 12, 2024, that the diabetes was treated with Levemir and Humalog. None of the above reviewed assessments by the Physician, Employee E18, or Nurse Practitioner, Employee E17, mentioned or addressed the regular refusals of insulin.

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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. 48347 Based on review of facility policy, review of clinical records, resident interviews, and staff interviews, it was determined the facility failed to ensure that resident care plans were reviewed and revised to reflect the residents' status and care needs related to communication and aggressive behavior for two of eights residents reviewed. (Resident R507 and R205) Findings include: Review of the facility policy Comprehensive Care Plan dated March 2020, revealed A plan of care will be created for each resident that includes but not limited to measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. Continued review of this policy revealed that Identifying problem areas and their causes, and developing interventions, that are targeted and meaningful to the resident, are the endpoints of the interdisciplinary process. The Assessments of the residents are ongoing and care plans are revised as information about the residents and residents condition changes. Review of Resident R507's Quarterly minimum data set (MDS- a federal mandated resident assessment and care screening) dated June 7, 2024, revealed resident R507 was admitted into the facility March 2, 2024, with diagnosis' dementia, renal deficiency, and hypertension. Further review of resident R507's MDS revealed that resident R507's preferred language is Spanish and has also combined with a hearing deficit, making communication difficult. Review of resident R507 comprehensive care plan dated March 13, 2024, revealed that residents R507 has difficulty communicating related to hearing loss, there is no intervention of goals related to speech/ language. This care did not include an updated assessment pof residents communication barrier. Review of resident R507's clinical record nursing progress note dated June 11, 2024, revealed the resident is Spanish speaking but speaks some English. Interview with Resident R 507's family representative on June 12, 2024, at 10:40 a.m. states that resident R 507 has no family in the area. She has been resident R507's neighbor for forty years. This representative stated that the resident R 507 does not speak any English. The representative continued to state that she visits the resident twice weekly and is available for the resident to call her if needed. Interview with licensed nurse, Employee E15 on June 12, 2024, at 11:46 a.m. revealed that resident R 507 speaks little English, the employee stated that she uses her phone, an app translator to communicate with resident R507. Review of Resident R507's care plan revealed the care plan had not been updated with communication barrier interventions (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R205's Quarterly minimum data set (MDS- a federal mandated resident assessment and care screening) dated May 5, 2024, revealed resident R205 was admitted into the facility April 9, 2024, with diagnosis' Dementia, anxiety and depression, hypertension, renal insufficiency, and diabetes. Further review of the MDS revealed that resident R 205 possess a severely impaired cognitive skill along with communication barrier, the resident speaks Cantonese. Review of psychiatrist consultation note dated February 9, 2024, revealed that the nursing staff has been reporting aggressive and agitated behaviors. Review of resident R205's clinical record nurse progress note dated March 1, 2024, reveled physical aggression, resident hit another resident on her hand. Review of resident R 205's clinical record nursing progress note dated March 17, 2024, revealed a report that resident R 205 hit a visitor. Review of resident R 205's clinical record nursing note dated March 26, 2024, revealed resident R 205 slapped another resident on her face. Review of resident R 205's comprehensive care plan revealed resident R 205 is at risk for behavior symptoms related to dementia, language barriers, agitated and combative at times, with a priority or desired goal of free or reduced behavior symptoms through next review. The Care plan does not include an updated assessment or plan for resident R 205's abusive behavior. 28 Pa. Code 211.10(b) Resident care policies 28 Pa. Code (d)(1) Nursing services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38947 Based on interviews and the review of clinical records, it was determined that the facility failed to maintain acceptable parameters of nutritional status related to a resident's recorded weights for 1 out of 37 residents (Resident R112). Findings include: Review of the policy, Resident Weights, with an effective date of March 2020 indicated that the nursing staff will measure resident weights upon admission and record the weights in each resident's electronic record. The policy also indicated that weight changes of 5% or more will be retained, and if the weight is verified, nursing will notify the dietician. Continued review of the policy indicated that the dietician wil review resident weights monthly to follow individual weight trends over time. The policy also indicated that negative trends will be evaluated by the treatment teams as to whether or not the criteria for significant weight change has been met. Review of the June 2024 physician orders for Resident R112 indicated that the resident was admitted into the facility on [DATE], with diagnosis that included the following: lymphedema (a condition that results in swelling of the leg or arm); tachycardia (increase heart rate); hypotension (high blood pressure), and chronic kidney disease (gradual loss of kidney function that can lead to chronic kidney disease). Review of the electronic clinical record included the following weights for Resident R112: January 16, 2024@6:07 p.m.---152lbs (admission weight recorded) January 17, 2024@11:45 a.m. ---171.2 lbs February 6, 2024@10:20 p.m.---219.4 lbs March 12, 2024@3:15 p.m.---128 lbs March 20, 2024@11:58 a.m.--- 128.6 lbs April 3, 2024@1:21 p.m.----125.0 lbs June 10, 2021@12:53 a.m.---112.6lbs (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a clinical note from the register dietician (Employee E10) dated January 17, 2024, at 2:34 p.m. indicated that the resident's admission weight recorded at the facility was 152lbs., and that the resident's weight at the hospital was also 152lbs., Review of the note indicated that the resident 's re-weight on January 17, 2024, was 171.2. Continued review of the progress note indicated that when asked by the dietician, the resident informed the dietician that she was unsure of her usual body weight, but reported to the dietician that she thinks that the 171.2lbs. that was recorded on January 17, 2024 was an accurate weight for her. Per the registered dietician note, the dietician reported that she will delete the weight of 152 lbs. based on her conversation with the resident: Will strike-out weight of 152# given likely inaccurate entry and continue to monitor. Continued review of the above referenced note did not show evidence that the dietician ensured that the an accurate admission weight was utilized to ensure that the resident's nutritional status was being accurately assessed and monitored. During an interview with the registered dietician on June 24, 2024 at 1:20 p.m. the dietician reported that she assumed that nursing staff did not weigh the resident upon her admission on January 16, 2024, and that the nursing staff just recorded the weight of 152 lbs. from the hospital since, this is what they(nursing staff) usually do. Employee E9 reported that although she assumed this, that she did not verify with them if this was true or not. As a result, the dietician requested a re-weight. When the re-weight was obtained, nursing recorded the resident as weighing 171.2 lbs. on January 17, 2024 at 11:45 a.m. The dietician reported that because she assumed that the resident was not weighed on the date of her admission and that nursing just inputted her weight from the hospital, she recorded the weight of 171.2 as the official admission weight once she received that weight as the re-weight. The dietician also reported that she also spoke with the resident who reported that the weight of 171.2 lbs. was more accurate than the 151 lbs: Resident reports she is unsure of UBW (usually body weight) but reports she thinks 171.2# is an accurate weight. Will strike-out weight of 152# given likely inaccurate entry and continue to monitor. Review of the resident's clinical record indicated that on February 6, 2024 the resident's weight was taken and recorded as being 219.4 lbs., which is a significant weight gain of 28.1% from the last weight of January 17, 2024 weight of 171.2lbs. (48.1lbs loss). Continued review of the clinical record did not show evidence that this significant weight gain was addressed by nursing staff or the dietician until February 20, 2024, which is 14 days after the weight of 219.4 was recorded by nursing staff. Continued review of the clinical record did not show evidence that the weight gain was acknowledge by nursing or the dietician and that a re-weight was obtained in a timely manner to ensure that resident's nutritional status was being accurately assessed and monitored. During an interview with the registered dietician on June 17, 2024, at 1:20 p.m. it was confirmed that there was no documentation to show evidence that the above referenced significant weight gain that was recorded by nursing staff on February 6, 2024 was addressed by the dietician in a timely manner. The dietician confirmed that she did not address the weight gain reported on February 6, 2024 until February 20, 2023. The dietician reported that she asked nursing staff for a re-weight on February 20, 2024 due to the significant weight gain that was recorded on February 6, 2024. The dietician confirmed that another weight was not taken by nursing staff for Resident R112 until March 12, 2024, 21 days after the significant weight gain of 28. 1% (48.2 pounds) was recorded for the resident. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of the resident's clinical record indicated that the resident was weighed on March 12, 2024 and the resident's weight was recorded as being 128 lbs. Review of the clinical record -41.7% weight loss (91.4lb loss) from February 6, 2024 through March 12, 2024. Review of the clinical record regarding the above referenced weight loss did not show evidence that the weight gain was acknowledge by nursing or the dietician, and that a re-weight was obtained in a timely manner to ensure that resident's nutritional status was being accurately assessed and monitored. During an interview with the registered dietician on June 17, 2024, at 1:20 p.m. it was confirmed that there was no documentation from the dietician that she was aware of the recorded significant weight loss of -41. 7% (91.4 lb loss) from February 6, 2024 through March 12, 2024, addressed the weight loss, or asked for a re-weight due to the recorded -41.7% weight loss (91.4 lb weight loss) recorded from February 6, 2024 through March 12, 2024. Continued review of the clinical record indicated that that a re-weight was not obtained in a timely manner and that the re-weight was obtained from the resident on March 20, 2024, 8 days later. The clinical record documented that resident's re-weight as 128.6 (only 6 ounces more than the weight taken on March 12, 2024), which still constituted a significant weight loss of -41.4% (90.8lb weight loss) when compared to the resident's weight loss that was taken on February 6, 2024. There was no evidence in the clinical record that this significant weight loss of -41.4 was addressed by the dietician when the re-weight confirmed that the weight loss was significant. During an interview with the registered dietician on June 17, 2024, at 1:20 p.m. it was confirmed that the re-weight was obtained on March 20, 2024, which recorded the resident's weight at 128.6 which constituted significant weight loss. It was also confirmed by Employee E9 that she did not address this weight loss, which was supported by a re-weight that was done. Continued review of the resident's clinical record indicated that the resident was weighed on April 3, 2024 and the resident's weight was recorded as being 125 lbs. Review of a weight obtain on June 10, 2024 recorded the resident's weight at being 112.6 lbs., which constitutes -9.92% weight loss (12.4 lb loss). There was no documentation in the clinical record indicating that this weight loss was addressed, or a re-weight was requested to ensure that resident's nutritional status was being accurately assessed and monitored. During an interview with the registered dietician on June 17, 2024, at 1:20 p.m. it was confirmed that the weights recorded constituted a significant weight loss of 9.92% and there this was not addressed in by the dietician in the clinical notes, and there was no documentation on whether or a not a re-weight was requested. The dietician reported during the above referenced interview that she asked nursing staff for a re-weight for the June 10, 2024, but has not received the re-weight for the resident. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 211.12(d)(1)(3) Nursing services

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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** 46106 Based on review of facility policies and clinical records and interviews with residents and staff, it was determined that the facility failed to ensure that pain management was provided that was consistent with professional standards of practice, for one of 37 residents reviewed (R71). Findings include: Review of facility policy, Administering Medications dated March 2020 revealed, Medications must be administered one hour before and after the prescribed times. Interview on June 17, 2024, at 10:07a.m. Resident R71 stated that her pain medications were not received this morning and that she was in a lot of back pain. Review of Resident R71's record revealed that she was admitted to the facility on [DATE], with diagnoses including low back pain, infection, and inflammatory reaction due to other cardiac and vascular devices. Review Resident R71 physician order on June 17, 2024, at 10:10 am revealed order on May 23, 2024, Gabapentin oral capsule give 100 mg by mouth three times (9am, 1pm and 5pm) a day for pain. Review of Medication Administration Records (MARs) for Resident R71 for June 17, 2024, revealed that the resident's Gabapentin pain medication 100 mg. was not given per physician order and it was administered more than one hour after prescribed time. Interview on June 17, 2024, at 10.12 a.m. Employee E7, licensed nurse, confirmed that she had not administered Resident R71's Gabapentin yet because she just hasn't gotten around to giving it yet and because short a nurse on the cart. 28 Pa Code 211.10(c) Resident care policies 28 Pa Code 211.12(d)(1) Nursing services

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46106 Based on staff interviews and the review of clinical records, it was determined that the facility failed to maintain complete and accurate records related to dialysis communication for one of 37 dialysis residents reviewed (Resident R71). Findings include: Review of Resident R71's clinical record revealed that the resident was admitted to the facility on [DATE], and has a diagnosis of End-Stage Renal Disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life). Review of Resident R71's physician order, dated May 24, 2024, revealed that Resident R71 receive dialysis treatment in the facility on Monday through Friday. Review of Resident R71's Hemodialysis Communication Record revealed that on, May 24, 2024, through June 14, 2024 it didn't have information on Pre-Weight before going to dialysis. On each of the communication record the top part say nursing home use only prior to dialysis. Interview with the Director of Nurse employee E2, confirmed that it's the nursing responsibility to due paper work for residents prior going to dialysis. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.5(f) Clinical records 28 Pa Code 211.5(g)(h) Clinical records 28 Pa Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(3) Nursing services 28 Pa.Code 211.12(d)(1)(5) Nursing services

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 38947 Based on interviews and the review of clinical records it was determined that that facility failed to ensure that behavioral health services were provided to 1 out of 37 residents who stated that she wanted to die (Resident R606). Findings include: Review of the Resident R606's June 2024 physician orders included the following diagnosis: aortic aneurism (a bulge in the wall of an individual's aorta that can rupture or dissect and cause life-threatening bleeding, hypertension (high blood pressure); epilepsy (a brain condition that causes recurring seizures) and glaucoma (a condition in which the never that provides information to the brain is damaged and will cause gradual vision loss if not treated). Review of a nursing note dated May 28, 2024, at 1:40 a.m. indicated that the resident complained of chest pain was provided with 3 tablets of Nitrostat (tablets used to relieve chest pain) administered but provided no relief to the resident. Emergency Medical Services were contacted, but when they arrived, the resident refused to go and stated that she wanted to die: Resident refused to go the hospital when 911 arrived, resident stated in the present of a CNA that she wants to die. VS-118/72-70-20-98.0-96% via NC. MD . notified. Continued review of the resident's clinical record did not show evidence that the resident was properly assessed by nursing staff regarding the comment that she made about not wanting to go to the hospital, and wanting to die instead (e.g., why did she make this statement; did she have a plan, was she depressed, etc) to determine if the resident was in need of and/or wanted to be referred for any additional services to (e.g. psychiatric and/or counseling services) to further assess any behavioral health needs that the resident may have. Review of the clinical record indicated that the resident was seen by the nurse practioner the next day, but there was no documentation that the nurse practitioner was aware of the statement that the resident made about the reason that the resident made about not wanting to go to the hospital. Review of a progress notes written by the nurse practitioner on regarding Resident R606 on May 28, 2024, at 10:36 a.m. states that she had chest pain overnight, does not want to go to the hospital or get any further testing done, pt denies pain this morning. During an interview with the Unit Manager (Employee E3) on June 17, 2024, at 11:32 a.m. it was discussed that there was no documentation that the comment that resident made regarding wanting to die was assessed by nursing staff or the nurse practitioner to see if any additional services were needed to address her behavioral health needs. 28 Pa Code 211.12(d)(1)(3)(5) Nursing services.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609 Based on review of clinical records, facility policy and staff interview determined the facility failed to ensure one of 37 residents reviewed was free from a significant medication error (Resident R174). Findings include: Review of the facility policy titled Administering Medications, effective March 2020 states medications shall be administered in a safe and timely manner, and as prescribed. The individual administering the medication must check for the following five rights of administering medications: a. Right Resident b. Right time and frequency of administration c. Right Dose d. Right Route e. Right Drug Resident R174 was admitted to the facility on [DATE], diagnosed with Diabetes Mellitus (the body cannot regulate and use sugar as fuel), high blood pressure and unspecified intellectual disabilities. Review of Resident R174 Nursing progress note dated, May 7, 2024, stated at 10:50 a.m. Resident R174 received her roommate's medications in error. The medications that were given to Resident R174 were, Apixaban 2.5 mg (prevents blood clots), aspirin 81 mg, Ferrous sulfate 325 mg (iron supplement) Glipizide (treats high blood sugar levels caused by diabetes mellitus) Meloxicam 15 mg (anti-inflammatory for pain) Memantine 10mg (cognitive-enhancing medication) Ocuvite Extra (supplement for the eyes) and Pepcid 20mg (stomach acid reducer). The resident was seen by a nurse practioner, and orders were received to send the resident to the emergency room for evaluation where she was admitted to the hospital. Review of Resident R174 hospital records explained that on May 7, 2024, at approximately 8:30 a.m. Resident R174 received her dose of the medication metformin (used to treat high blood sugar levels that are caused by a type of diabetes mellitus) and two hours later she received her roommate's glipizide. Shortly afterwards the resident started feeling light-headed and dizzy. On her initial arrival to the emergency room her blood glucose (sugar levels) was 67 (A normal fasting blood sugar level is between 70 and 100 milligrams per deciliter (mg/dL) which was later corrected by administering intravenous (I.V.) fluids. The resident was admitted to ICU for blood glucose checks every two hours for the incidental glipizide ingestion. The resident's glucose levels remained stable and was downgraded to a medical/surgical floor and then was discharge back to the facility on [DATE]. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on June 14, 2024, at 12:33 p.m. with the nurse, Licensed Practical Nurse (LPN) Employee E6 that administered the wrong medication to Resident R174. The LPN stated, As soon as I did it (gave the wrong medication) I knew and went right to my supervisor and told them. I was distracted when someone started talking to me as I was pouring their medications and I gave both to Resident R174. 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(3) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 38947 Based on interviews and the review of clinical records, it was determined that the facility failed to ensure complete and accurate clinical records for 1 out of 37 records reviewed (Resident R98). Findings include: Review of the January 2024 physician orders for Resident R98 included the following diagnosis: diabetes (a condition that happens when your blood sugar is too high); absence of left leg below the knee and absence of right toes; hypertension (high blood pressure) and dependence of renal dialysis (the process of removing excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). Continued review of the resident's June 2024 physician orders included a physician's order dated September 29, 2023 for the resident to attend dialysis treatment 5 days. The resident's start time for dialysis treatment was listed as 8:15 a.m. Review of nurse documentation on October 9, 2024 at 12:10 p.m. by Employee E12 (licensed nurse) indicated that the resident returned from in house dialysis due to being hypotensive (low blood pressure) and change in mental status: Resident returned to unit from in house Dialysis d/t being hypotensive and change of mental status. Continued review of the clinical record did not include any additional information, monitoring or notifying the physician related to the change in the resident's health care status documented by the licensed nurse. Review of nurse documentation on October 10, 2024 at 12:30 p.m. by Employee E12 (licensed nurse) indicated that the resident returned from in house dialysis due to being hypotensive (low blood pressure) and change in mental status: Resident returned to unit from in house Dialysis d/t being hypotensive and change of mental status. Continued review of the clinical record did not include any additional information, monitoring or notifying the physician related to the change in the resident's health care status documented by the licensed nurse. Review of nurse documentation on October 11, 2024 at 12:45 p.m. by Employee E12 (licensed nurse) indicated that the resident returned from in house dialysis due to being hypotensive (low blood pressure) and change in mental status: Resident returned to unit from in house Dialysis d/t being hypotensive and change of mental status. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the 4th floor Unit Manager (Employee E14) for Resident R98 on June 17, 2024, at 2:19 p.m. the documentation reviewed with the Unit Manger indicated that the resident finished his dialyses treatment on those days and that there was no concern with his blood pressure or any changes with his mental status. A report from the dialyses nurse (Employee E13) was also obtained during this time she also reported that there were no reported changes to the resident and that he completed his dialysis treatment on all three days. Continued interview with the above referenced Unit Manger for Resident R98 indicated that there was no explanation as to why Employee E12 documented Resident R98 as having a change in condition on the above referenced dates when the documentation from dialysis and the dialysis nurse interview did not support Employee E12's claim of him being hypotensive and having a change of mental status. 28 Pa. Code 211.5 (f) Medical records 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1) Nursing services

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347 Based on clinical records and staff interviews, it was determined that the facility failed to offer and or provide the influenza and pneumococcal immunization for 10 of ten residents reviewed. (Resident R 15, R36, R39.R 73, R110, R111, R190, R204, R228, R231). Findings include: Review of facility policy titled Influenza vaccine dated November 2018 revealed that all residents who have no medical contradictions to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccination against influenza. Further review of this document revealed that for those residents who receive the vaccine, the date of vaccination, the lot number, expiration date, person administrating, and site of vaccination will be documented in the residents medical record. A resident's refusal shall be documented in the resident medical record. Review of the The Advisory Committee on Immunization Practices (ACIP) refers to a group of medical and public health experts that develops recommendations on how to use vaccines to control diseases in the United States. ACIP's recommendations stand as public health advice that will lead to a reduction in the incidence of vaccine preventable diseases and an increase in the safe use of vaccines and related biological products, Pneumococcal ACIP Vaccine recommendations dated November 22, 2024 , revealed the Advisory Committee on Immunization Practices (ACIP) recommended 13-valent pneumococcal conjugate vaccine (PCV13) in series with 23-valent polysaccharide vaccine (PPSV23) for all adults aged [AGE] years. The regulation requires that each resident is offered pneumococcal immunization, unless the immunization is medically contraindicated, or the resident has already been immunized. There should be documentation in the medical record if there is reason to believe that pneumococcal vaccine(s) was given previously, but the date cannot be verified, and this had an impact upon the decision regarding administration of the vaccine(s). Facilities should follow the CDC and ACIP recommendations for vaccines. Review of the Centers for Doease Control and Prevention (CDC) Morbidity and Mortality Weekly report dated August 25, 2023 revealed Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices - United States, 2023-24 Influenza Season : The ACIP recommends that adults aged sixty-five years preferentially receive any one of the following higher dose or adjuvanted influenza vaccines: quadrivalent high-dose inactivated influenza vaccine (HD-IIV4), quadrivalent recombinant influenza vaccine (RIV4), or quadrivalent adjuvanted inactivated influenza vaccine (aIIV4). If none of these three vaccines is available at an opportunity for vaccine administration, then any other age-appropriate influenza vaccine should be used. Review of the clinical record for Resident R15 revealed the resident was admitted to the facility on [DATE]. Review of R15's immunization record revealed no evidence that the resident received the vaccines influenza or pneumococcal or that the facility offered the vaccines. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record for Resident R36 revealed the resident was admitted to the facility on [DATE]. Review of R 36's immunization record revealed no evidence that the resident received the vaccine pneumococcal or that the facility offered the vaccine. Review of the clinical record for Resident R73 revealed the resident was admitted to the facility on [DATE]. Review of R 73's immunization record revealed no evidence that the resident received the vaccines influenza or pneumococcal or that the facility offered the vaccines. Review of the clinical record for Resident R 110 revealed the resident was admitted to the facility on [DATE]. Review of R110's immunization record revealed no evidence that the resident received the vaccine pneumococcal or that the facility offered the vaccine. Review of the clinical record for Resident R 111 revealed the resident was admitted to the facility on [DATE]. Review of R 111's immunization record revealed no evidence that the resident received the vaccines influenza or pneumococcal od that the facility offered the vaccines. Review of the clinical record for Resident R190 revealed the resident was admitted to the facility on [DATE]. Review of R190's immunization record revealed no evidence that the resident received the vaccines influenza or pneumococcal or that the facility offered the vaccines. Review of the clinical record for Resident R204 revealed the resident was admitted to the facility on [DATE]. Review of R204's immunization record revealed no evidence that the resident received the vaccines influenza or pneumococcal or that the facility offered the vaccines. Review of the clinical record for Resident R228 revealed the resident was admitted to the facility on [DATE]. Review of R 228's immunization record revealed no evidence that the resident received the vaccines influenza or pneumococcal or that the facility offered the vaccines. Review of the clinical record for Resident R 231 revealed the resident was admitted to the facility on [DATE]. Review of R 231's immunization record revealed no evidence that the resident received the vaccine influenza or that the facility offered the vaccine. Interview with infection control nurse Employee E16 on June 14, 2024, at 11:41 a.m. confirmed that there was no documentation of the pneumococcal or influenza vaccine. Employee E16 believed that information was located somewhere else and would find it and update the resident clinical records. Review of Records on June 17, 2024, at time of survey exit the records have not been received and the residents' records were not updated. 28 Pa. Code 210.14 (a) Responsibility of licensee 28 Pa. Code 201. 18(1) Management

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277 Based on review of facility policy, observations, review of clinical records, review of facility documents, and staff interviews it was determined that the facility failed to maintain an effective pest control program in the main kitchen, laundry, and one resident room. Findings Include: Review of pest control report dated February 19, 2024, revealed the kitchen is seeing roaches . a lot of roach activity behind the wall covering by the steamers . recommended a clean out. The administration would like to try conventional treatments first. Review of pest control report dated February 22, 2024, revealed the kitchen was treated for roach activity. Review of pest control report dated May 8, 2024, revealed the pest control company met with the Nursing Home Administrator, Employee E1, and the dietary manager to discuss roaches in kitchen oven. Oven was opened and bait was applied to the inside of the oven. Review of pest control report dated May 15, 2024, revealed laundry was treated for roach activity. Review of pest control report dated May 22, 2024, revealed tray line (located in the main kitchen) and dishwashing area were treated for roach activity. Review of pest control report dated May 23, 2024, revealed most of the roach activity seen in the dishwashing room [located in the main kitchen] is most likely coming from the laundry room. Heavy activity seen on the laundry room monitors which is below the dishwashing area Review of pest control report dated May 29, 2024, revealed the kitchen is showing some [roach] activity around the dishwasher. Continued review of the report revealed it was believed that the laundry room was the epicenter of the roach activity. The issue in laundry was just brought to the pest control company ' s attention last service. Continued review of pest control reports dated June 4, 2024, revealed a clean out per recommendations from pest control report on February 19, 2024, was not completed until June 4, 2024. Continued review of pest control report dated June 4, 2024, revealed treated kitchen for after hours roach clean out. Treated dishwasher area, behind stove, in between ice maker, underneath sinks, and common areas throughout the kitchen. Observations of the main kitchen and food storage areas on June 12, 2024, at 10:15 a.m. with the Food Service Director, Employee E5, revealed the doors for the outside loading dock/food delivery area led directly into the dry food storage area. Observations revealed the door sweep was not completely sealed, allowing easy access to the building for common household pests and rodents. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Follow-up observations in the main kitchen on June 13, 2024, at 1:15 p.m. with the Food Service Director, Employee E5, revealed a live cockroach on the wall behind the steam tables. Review of nursing progress note on February 25, 2024, revealed that the nursing supervisor was called to the room and observed several insects in the corner of the sheets and head of the bed. Administrator notified. Review of the facility's pest control management service inspection report dated February 8, 2024, revealed that management company was on site of the facility for weekly service pest control. The general comments/ instructions note on this date of inspection was Inspected and treated room [ROOM NUMBER] for mice activity. During service observed a bed bug on the bed near the window. Spoke with the administrator (Employee E1). Review of the facility's pest control management service inspection report dated February 15, 2024, revealed that management company was on site of the facility for weekly service pest control. The general comment/ instructions of this inspection noted inspected and treated room [ROOM NUMBER] for first bedbug treatment spoke with the administrator (Employee E1). Review of the facility's pest control management service inspection report dated February 22, 2024, revealed that management company was on site of the facility for weekly service pest control. The general comments/ instructions note on this date of inspection was Treated 2nd bedbug treatment spoke to the administrator (Employee E1). Review of the facility's pest control management service inspection report dated February 29, 2024, revealed that management company was on site of the facility for weekly service pest control. The general comments/ instructions note on this date of inspection was Inspected and treated room [ROOM NUMBER] for third bedbug treatment. Review of the facility's pest control management service inspection report dated March 20, 2024, revealed that management company was on site of the facility for weekly service pest control. The general comments/ instructions note on this date of inspection was Inspected and treated room [ROOM NUMBER] for a fourth bedbug treatment. Observed live activity on curtain in knitting box by window. Continued review of this inspection revealed the first-time surrounding rooms 251 and room [ROOM NUMBER] were inspected for bedbug activity. No activity seen Administrator was notified via phone. Interview with Administrator, Employee E1 revealed that he was unaware of the original sighting and confirmed that the initial treatment was delayed until sighting was confirmed. Review of a facility reported incident that was reported on March 19, 2024, a staff member observed a bed bug in room [ROOM NUMBER]. Further review of this document revealed that the pest control company was contacted inspection and treatment on March 20, 2024. This was reported by administrator Employee E1. Review of the facility,s policy titled Laundry Services dated March 2020, revealed that the facility will provide laundry services for all residents . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395338	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Immaculatemarycenter for Rehabilitation&healthcare	2990 Holme Avenue Philadelphia, PA 19136

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Center for Disease Control and Prevention Environmental infection Control Guidelinesdated 2002, title Laundry and Bedding revealed contaminated textiles and fabrics often contain high numbers of micro organisms from body substances, including blood, skin, stool, urine, vomit and other body tissues and fluids Further review revealed that Contaminated textiles and fabrics are placed into bags or other appriopate containment Tour of the facility's laundry room on June 13, 2024 at 12:44 p.m., accompanied by maintance director Employee E19 revealed the building laundry chute being utilized by spoiled laundry. This laundry from the laundry chute was observed to be loose and unwrapped. Interview with Employee E 19 at time of observation , confirmed that the laundry was not bagged properly. 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 210.18 (e)(2.1) Management 28 Pa. Code 211.1 (b) Reportable Diseases 48347 Based on facility policy, resident and staff interviews, review of facility documents, it was determined that the facility failed to maintain an effective pest control system for one resident's room relating to delinquent bedbug treatment. Findings include: Review of facility policy titled pest Control dated March 2020 revealed that the facility shall maintain an effective pest control program. Review of nursing progress note on February 25, 2024, revealed that the nursing supervisor was called to the room and observed several insects in the corner of the sheets and head of the bed. Administrator notified. Review of the facility's pest control management service inspection report dated February 8, 2024, revealed that management company was on site of the facility for weekly service pest control. The general comments/ instructions note on this date of inspection was Inspected and treated room [ROOM NUMBER] for mice activity. During service observed a bed bug on the bed near the window. Spoke with the administrator (Employee E1). Review of the facility's pest control management service inspection report dated February 15, 2024, revealed that management company was on site of the facility for weekly service pest control. The general comment/ instructions of this inspection noted inspected and treated room [ROOM NUMBER] for first bedbug treatment spoke with the administrator (Employee E1). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395338	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Immaculatemarycenter for Rehabilitation&healthcare	2990 Holme Avenue Philadelphia, PA 19136

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's pest control management service inspection report dated February 22, 2024, revealed that management company was on site of the facility for weekly service pest control. The general comments/ instructions note on this date of inspection was Treated 2nd bedbug treatment spoke to the administrator (Employee E1). Review of the facility's pest control management service inspection report dated February 29, 2024, revealed that management company was on site of the facility for weekly service pest control. The general comments/ instructions note on this date of inspection was Inspected and treated room [ROOM NUMBER] for third bedbug treatment. Review of the facility's pest control management service inspection report dated March 20, 2024, revealed that management company was on site of the facility for weekly service pest control. The general comments/ instructions note on this date of inspection was Inspected and treated room [ROOM NUMBER] for a fourth bedbug treatment. Observed live activity on curtain in knitting box by window. Continued review of this inspection revealed the first-time surrounding rooms 251 and room [ROOM NUMBER] were inspected for bedbug activity. No activity seen Administrator was notified via phone. Interview with Administrator, Employee E1 revealed that he was unaware of the original sighting and confirmed that the initial treatment was delayed until sighting was confirmed. Review o f Pennsylvania Department of Health Event Details of reported Event # 995548 revealed that an incident was reported on March 19, 2024, a staff member observed a bed bug in room [ROOM NUMBER]. Further review of this document revealed that the pest control company was contacted inspection and treatment on March 20, 2024. This was reported by administrator Employee E1. Review of the facility,s policy titled Laundry Services dated March 2020, revealed that the facility will provide laundry services for all residents . Review of the Center for Disease Control and Prevention Environmental infection Control Guidelinesdated 2002, title Laundry and Bedding revealed contaminated textiles and fabrics often contain high numbers of micro organisms from body substances, including blood, skin, stool, urine, vomit and other body tissues and fluids Further review revealed that Contaminated textiles and fabrics are placed into bags or other appriopate containment Tour of the facility's laundry room on June 13, 2024 at 12:44 p.m., accompanied by maintance director Employee E19 revealed the building laundry chute being utilized by spoiled laundry. This laundry from the laundry chute was observed to be loose and unwrapped. Interview with Employee E 19 at time of observation , confirmed that the laundry was not bagged properly. 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 210.18 (e)(2.1) Management 28 Pa. Code 211.1 (b) Reportable Diseases