STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395110	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER: Oakwood Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2109 Red Lion Road Philadelphia, PA 19115	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on review of facility policies, clinical record reviews and interviews with staff, it was determined that the facility did not ensure that all allegations of abuse and neglect were reported immediately to the Pennsylvania Department of Health for two of 26 residents reviewed. (Resident R24, R433)

Findings Include:

A review of the facility policy titled Oakwood Health and Rehabilitation Center Policy and Procedure, revised September 2023, revealed the following under Section #6, Investigating and Reporting: Once an allegation of abuse has been made, the supervisor who initially received the report must inform the Administrator of Nursing immediately and initiate gathering the requested information. An investigation must be directed by the Administrator or designee immediately.

Review of Resident 24's clinical record revealed the resident was admitted to the facility on [DATE], and had a diagnosis of muscle wasting and atrophy, heart failure, need for assistance with personal care, other abnormalities of gait and mobility, disorder of muscle, adult failure to thrive, difficulty in walking, muscle weakness.

A review of Resident R24's annual Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 14, reflecting cognitive intact. The functional abilities section of the MDS indicated that Resident R24 requires partial/moderate assistance with toileting hygiene tasks.

An interview conducted on June 2, 2025, at 12:35 p.m. revealed that Resident R24 reported pressing the call bell at 2:00 a.m. during the previous night shift due to being wet with urine and needing a brief change. However, the resident was not changed until 5:00 a.m. Resident R24 stated that she reported the incident to the current morning charge nurse, Employee E6, who advised her that she would notify the Director of Nursing, Employee E2.

On June 2, 2025, at 2:45 p.m., the surveyor informed the Director of Nursing, Employee E2, that Resident R24 had made an allegation of neglect, which had been reported to Employee E6. Employee E2 stated she was not aware of the allegation and would begin an immediate investigation. It was confirmed that the charge nurse, Employee E6, did not report the allegation of neglect to the Director of Nursing.

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 433's clinical record revealed the resident was admitted to the facility on [DATE], and had a diagnosis of adult failure to thrive, muscle wasting and atrophy, acquired absence of left leg above knee, and muscle spasm. A review of Resident R433's admission Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 15, reflecting cognitive intact. The functional abilities section of the MDS indicated that Resident R433 requires substantial/maximal assistance with toileting hygiene tasks. On June 5, 2025, at 10:35 a.m., a family interview was conducted for Resident R433. The interview revealed that when concerns are brought to the charge nurses, they remain at the nursing level and are not communicated to the administration. Earlier that morning, Resident R433 had been sitting in urine for approximately two hours while eating breakfast. She was not changed until the nursing aides had finished collecting breakfast trays. This concern was communicated to the Unit Manager, Employee E5, who apologized. On June 5, 2025, at 10:40 a.m., an interview was conducted with Resident R433, who reported that she pressed the call bell between 7:00 a.m. and 7:30 a.m. because she was wet with urine and needed a change. A nursing aide responded to the call bell but stated that it was breakfast time, and she needed to finish passing trays. Resident R433 expressed frustration, as she had to eat breakfast while sitting in urine. On June 5, 2025, at 10:50 a.m., an interview was conducted with the Unit Manager, Employee E5. She reported that she was aware of the allegation of neglect involving Resident R433 but did not report it to the Director of Nursing. On June 5, 2025, at 11:10 a.m., an interview with the charge nurse, Employee E6, revealed that she was aware of the allegation of neglect reported by Resident R24 and understood it needed to be reported within two hours. However, she failed to report it to the Director of Nursing due to the presence of surveyors on-site. 28 Pa. Code: 201.14(a)(c) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1)(e)(1) Management.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, and interviews with residents, family members, and staff, it was determined that the facility failed to provide the necessary assistance with activities of daily living (ADLs) to maintain proper grooming for five of the five residents reviewed (Residents R24, R53, R33, R93, R433) Findings: Review of Resident 24's clinical record revealed the resident was admitted to the facility on [DATE], and had a diagnosis of muscle wasting and atrophy, heart failure, need for assistance with personal care, other abnormalities of gait and mobility, disorder of muscle, adult failure to thrive, difficulty in walking, muscle weakness. A review of Resident R24's annual Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 14, reflecting cognitive intact. The functional abilities section of the MDS indicated that Resident R24 requires partial/moderate assistance with toileting hygiene tasks. An interview conducted on June 2, 2025, at 12:35 p.m. revealed that Resident R24 reported pressing the call bell at 2:00 a.m. during the previous night shift due to being wet with urine and needing a brief change. However, the resident was not changed until 5:00 a.m. Resident R24 stated that she reported the incident to the current morning charge nurse, Employee E6, who advised her that she would notify the Director of Nursing, Employee E2 Review of Resident 93's clinical record revealed the resident was admitted to the facility on [DATE], and had a diagnosis Parkinson's disease, muscle wasting and atrophy right and left ankle and foot, lack of coordination, dementia (memory loss) , difficulty in walking. A review of Resident R93's quarterly Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 8, indicating the resident is moderately cognitively impaired. The functional abilities section of the MDS indicated that Resident R93 partial/moderate assistance with toileting hygiene tasks. On June 2, 2025, at 12:45 p.m. an observation of Resident R93 was conducted revealing facial hair on the chin. License nurse, Employee E4 confirmed the observations. Review of Resident 33's clinical record revealed the resident was admitted to the facility on [DATE], and had a diagnosis of dementia, muscle weakness, muscle wasting and atrophy, contracture right hand, disorder of muscle, difficulty in walking. A review of Resident R33's annual Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 3, indicating the resident is severely cognitively impaired. The functional abilities section of the MDS indicated that Resident R33 dependent with toileting, hygiene tasks. A comprehensive care plan dated March 21, 2023, revealed routine nail care and as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On June 2, 2025, at 12:50 p.m. an observation was conducted of Resident R33 revealing long nails. Director of Nursing confirmed the observations and reported that staff will attempt to cut it. Resident R33 is nonverbal. A telephone interview with the family, conducted on June 2, 2025, at 1:32 p.m., revealed that the family desires for Resident R33 to have her nails kept short. Review of Resident 53's clinical record revealed the resident was admitted to the facility on [DATE], and had a diagnosis of dementia, muscle wasting. On May 1, 2025, Resident R53 was diagnosed with a fracture of the distal end of the right radius, with unspecified fracture morphology, and was provided with an arm sling for healing. A review of Resident R53's quarterly Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 4, indicating the resident is severely cognitively impaired. The functional abilities section of the MDS indicated that Resident R53 requires setup or clean-up assistance with toileting, hygiene tasks. An interview conducted on June 2, 2025, at 1:12 p.m. revealed that Resident R53 had long nails and was wearing an arm sling for her right fracture. Resident R53 wanted them to be cut. License Nurse, Employee E6 confirmed the observation. Review of Resident 433's clinical record revealed the resident was admitted to the facility on [DATE], and had a diagnosis of adult failure to thrive, muscle wasting and atrophy, acquired absence of left leg above knee, and muscle spasm. A review of Resident R433's admission Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 15, reflecting cognitive intact. The functional abilities section of the MDS indicated that Resident R433 requires substantial/maximal assistance with toileting hygiene tasks. On June 4, 2025, at 10:30 a.m., a resident council meeting was held with 12 alert and oriented residents (R7, R112, R104, R84, R26, R113, R56, R35, R87, R82, R68, R97). The residents reported that, on many occasions, nursing aides would turn off call bells without providing assistance, stating, I'm not your aide. They also noted that call bell response is worst during the shift change between 2:00 p.m. and 4:00 p.m., as well as during the evening shift from 3:00 p.m. to 11:00 p.m. On June 5, 2025, at 10:35 a.m., a family interview was conducted for Resident R433. The interview revealed that earlier that morning, Resident R433 had been sitting in urine for approximately two hours while eating her breakfast. She was not changed until the nursing aides finished collecting breakfast trays. This concern was communicated to the unit manager, employee E5 who apologized. On June 5, 2025, at 10:40 a.m., an interview was conducted with Resident R433, who reported that she pressed the call bell between 7:00 a.m. and 7:30 a.m. because she was wet with urine and needed a change. A nursing aide responded to the call bell but stated that it was breakfast time, and she needed to finish passing trays. Resident R433 expressed frustration, as she had to eat breakfast while sitting in urine. (continued on next page)

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	395110	A. Building B. Wing	06/05/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At approximately 8:30 a.m., Resident R433 pressed the call bell. A nursing aide entered the room and stated that she was not sure if Resident R433 was on her assignment and then turned off the call bell. At 8:50 a.m., the same nursing aide returned, confirmed that Resident R433 was on her assignment, and proceeded to provide care. On June 5, 2025, at 10:50 a.m., an interview with the unit manager, Employee E4, confirmed that she was aware of the situation involving Resident R433. 28 Pa. Code 211.10 (d) Resident care policies 28 Pa code 211.12.(d)(1)(5) Nursing services

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record reviews and interviews with staff, it was determined that the facility failed to follow the physician orders related to medication administration for one of 26 residents reviewed (Residents R433). Findings include: Review of Resident 433's clinical record revealed the resident was admitted to the facility on [DATE], and had a diagnosis of adult failure to thrive, muscle wasting and atrophy, acquired absence of left leg above knee, and muscle spasm. A review of Resident R433's admission Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 15, reflecting cognitive intact. A review of the clinical progress notes indicated a progress physician note dated on May 16, 2025 indicated resident admitted to the facility. She is alert and oriented. All medication were reviewd and verified with physician, [Employee E3]. Review of hospital's physician orders indicated that Resident R433 was prescribed Insulin Aspart Flex Pen 100 unit/ml Sopn inject 15-18 units under the skin in the morning and 15-18 units at noon and 15-18 units in the evening. Inject before meal take 15 u with breakfast and 18 units with lunch and dinner. Last time this was given: May 16, 2025, at 9:01 a.m. Sliding scale 200-250 =2 units, 251-300= 4 units, 301-350= 6 units, 351-400=8 units, call MD if BS<60 or >400 upon discharge on [DATE]. On June 5, 2025, at 10:50 a.m., an interview was conducted with the Unit Manager, Employee E5, who confirmed that the Medication Administration Record (MAR) for May 2025 did not reflect that the sliding scale insulin order from the physician was created or administered until May 21, 2025. A review of the progress notes showed no changes in the insulin orders by the facility's physician. The sliding scale insulin order should have been created and administered upon the resident's admission to the facility on May 16, 2025, as indicated in the hospital discharge documentation. On June 5, 2025, at 11:30 a.m., an interview with the Director of Nursing confirmed that the facility failed to follow the physician's order to administer insulin based on a sliding scale. The facility did not have a sliding scale insulin order in place until May 21, 2025. 28 Pa Code 211.12(d)(5) Nursing services