STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395182	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St John Neumann Ctr for Rehab & Healthcare	10400 Roosevelt Avenue Philadelphia, PA 19116

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on record review and staff interviews, the facility failed to ensure Minimum Data Set (MDS) assessments were completed within 14 days after the Assessment Reference Date (ARD) for four of seven sampled residents (Residents R32, R109, R16 and R164).Findings include:According to the RAI User's Manual, Chapter 2, Completion Timing, federally required MDS assessments must be completed (locked and signed) no later than 14 days after the Assessment Reference Date (ARD).Record reviews of the MDS submissions for Residents R32, R2, R3, and R4 showed that their scheduled assessments exceeded the required 14-day completion timeframe following the established ARD.Resident R32's ARD was June 21, 2025, for an annual assessment; the MDS was completed on July 14, 2025, exceeding the 14-day requirement.Resident R109's ARD was October 7, 2025, for a quarterly assessment; the MDS was completed on October 23, 2025, exceeding the requirement.Resident R16's ARD was June 17, 2025, for a quarterly assessment; the MDS was completed on Julu 2, 2025, exceeding the requirement.Resident R16's ARD was September 17, 2025, for the next quarterly assessment; the MDS was completed on October 15, 2025, exceeding the requirement.Resident R4's ARD was October 8, 2025, for a quarterly assessment; the MDS was completed on October 23, 2025, exceeding the requirement.During an interview on November 20, 2025, with the MDS Coordinator confirmed the assessments were not completed timely for Residents R32, R109, R16 and R164.28 Pa. Code 211.5(f) Clinical Records.

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 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** Based on review of clinical records, and staff interviews, it was determined that the facility failed to provide evidence of a Level 1 pre-screening for mental disorders/intellectual disabilities for one of 35 residents reviewed (Resident R52). Findings Include: Review of Resident R52's clinical record revealed resident admitted to the facility on [DATE], with diagnosis of Schizophrenia, Depression. Review of Resident R52's quarterly Minimum Data Set (MDS- federally mandated resident assessment and care screening) dated September 4, 2025, revealed a BIMS (Brief Interview for Mental Status) score of 09, indicating resident cognitively impaired. Further review of Resident R52's MDS dated [DATE], revealed the resident had diagnoses of schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Review of Resident R54's clinical record revealed no documented evidence the facility conducted a Level 1 PASARR screen for Resident R54. Interview on November 20, 2025, at 11:00 a.m. with the Nursing Home Administrator, Employee E1, confirmed the facility was unable to provide evidence of Resident R54's Level 1 PASARR screen. 28 Pa. Code 211.5 (f)(iv) Medical records.28 Pa. Code 211.10 (c) Resident care policies.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, interview with residents and review of facility provided documentation, it was determined that facility did not ensure to develop and implement a comprehensive resident centered care plan for two of 35 residents reviewed related to wound care and bedside rails (Resident R24, R29) Findings include: Review of Resident R24 's clinical record revealed that Resident R24 was admitted to the facility on [DATE], with diagnoses of, Intracerebral hemorrhage(stroke), Aphasia (Communication disorder that affects your ability to speak, understand, read, or write). Observation of Resident R24 on November 19, 2025 at 11:02 am revealed Resident R24 awake, in bed with Bilateral ¾ length rails, in up position, running from resident's shoulder to hip. Interview with Employee E8, Licensed Practical Nurse on November 19, 2025 at 11:12 confirmed findings of bilateral bed rails, in up position, running from resident's shoulder to hip. Review of Resident R24's clinical record revealed resident assessed for bedrails on October 25, 2025 and that bedrails are indicated at this time for positioning and bed mobility. Review of Resident R24's Comprehensive Care Plan on November 19, 2025, revealed no care plan in place for bed rails. Interview with Employee E8, Licensed Practical Nurse on November 19, 2025 at 11:14 am confirmed no care plan in place for bed rails Review of facility policy 'Interdisciplinary Care Planning Protocol,' revised on March 2025, indicates that Nursing provides overview of medical and nursing care regimes. Nursing provides input especially related to ADL, skin, weights, and safety needs. Review of Resident R29 clinical record revealed nursing progress note, dated November 15, 2025, stating that R29's skin alteration on right forearm was noted by nurse aide; nurse noted a large fluid filled blister that appears to have been partially drained. Area was cleansed and skin prep was applied. Wound care consult placed. RP and MD notified. Interview with Resident R29 (BIMS score 11), on Monday, November 17th, 2026 at 10:00 am, revealed that she does not know how or why the blister formed. Review of R29's care plan revealed no evidence of goals or interventions related to right forearm blister. 28 Pa Code 211.12 (d)(5) Nursing services 28 Pa. Code 211.12(d)(3) Nursing services.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, observations and interviews with staff, it was determined that the facility did not ensure that resident was appropriately assessed for risk of entrapment and did not obtain informed consent related to bedrails for one of 35 residents reviewed (Resident R24). Findings include:Review of Resident R24 's clinical record revealed that Resident R24 was admitted to the facility on [DATE], with diagnoses of, Intracerebral hemorrhage(stroke), Aphasia (Communication disorder that affects your ability to speak, understand, read, or write).Review of Resident R24's MDS (Minimum Data Set), Quarterly assessment dated [DATE], revealed that Resident R24 has a BIMS (Brief Interview for Mental Status) score of 0, indicating severe cognitive impairment.Observation of Resident R24 on November 19, 2025 at 11:02 am revealed Resident R24 awake, in bed with Bilateral 3/4 length rails, in up position, running from resident's shoulder to hip.Interview with Employee E8, Licensed Practical Nurse on November 19, 2025 at 11:12 confirmed findings of bilateral bed rails, in up position, running from resident's shoulder to hip.Review of Resident R24's clinical record revealed resident assessed for bedrails on October 25, 2025 and that bedrails are indicated at this time and Bedrails are indicated and serve as enabler to promote independence. Further review revealed that Resident has been provided with informed consent of the risks of utilizing bedrails and displayed understanding.Review of Resident R24's clinical record revealed resident assessed for bedrails on July 25, 2025. The assessment indicated that resident is currently using the bedrail for positioning and support. Further review revealed no recommendation made during assessment and no informed consent provided. Review of Resident R24's clinical record revealed resident assessed for bedrails on June 25, 2025. The assessment indicated that the resident is currently using the bedrail for positioning and support. Further review revealed bedrails are not indicated at this time.Review of Resident R24's clinical record revealed resident assessed for bedrails on June 16, 2025. The assessment indicated that the resident is currently using the bedrail for positioning and support. Further review revealed bedrails are not indicated at this time. Review of Resident R24's clinical record revealed resident assessed for bedrails on March 25, 2025. The assessment indicated that the resident is not currently using the bedrail for positioning and support. Further review revealed bedrails are not indicated at this time.Review of Resident R24's clinical record revealed resident assessed for bedrails on December 25, 2025. The assessment indicated that the resident is currently using the bedrail for positioning and support. Further review revealed no bedrail recommendations made during assessment and no informed consent provided.Review of Resident R24's clinical record revealed resident assessed for bedrails on December 21, 2025. The assessment indicated that the resident is currently using the bedrail for positioning and support. Further review revealed bedrails are indicated and serve as an enabler to promote independence. No documented evidence of informed consent of risks of utilizing bedrails and displayed understanding.Interview with Employee E2, Director of Nursing on November 20, 2025 at approximately 10:30am confirmed the above listed findings.28 Pa. Code 211.10(d) Resident care policies28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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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. Based on observation, interview, and record review, it was determined that the facility failed to maintain a medication error rate of less than 5% during a medication administration pass. Three medication errors out of 26 medication administration opportunities observed during medication administration (Medication Error Rate of 11.54%).Findings include: Review of physician order for Resident R89 dated September 21, 2025, revealed an order for Cyanocobalamin Tablet 1000 MCG (A supplement medication) Give one tablet by mouth one time a day. Review of physician order for Resident R183 dated September 21, 2025, revealed an order for Nitroglycerin Sublingual Tablet Sublingual 0.4 MG (Nitroglycerin) Give 1 tablet sublingually as needed for Chest Pain. Review of physician order for Resident R183 dated October 8, 2025, revealed an order for metformin HCl Oral Tablet 500 MG (Metformin HCl) Give 1 tablet by mouth two times a day for DM dosing with meal. Observation of the morning medication pass for Resident R89 on November 17, 2025, at 9:59 a.m., with Employee E9, licensed practical nurse, revealed that the employee looked at the medication order and read Cyanocobalamin Tablet 1000 MCG, however she took Oyster Calcium 500 mg, 2 tablets and proceeded to administer the medication. After the employee removed the medication, surveyor intervened and stopped the employee from administering the wrong medication. Observation of the morning medication pass for Resident R183 on November 17, 2025, at 10.28 a.m., with Employee E9 revealed that the resident complained to the employee that he was having chest pain. Employee removed Nitroglycerin Sublingual Tablet from the cart and administered to the resident orally with water. Residents were observed swallowing the medication. Continued observation of the medication pass for Resident R183 revealed that the employee administered the medication Metformin HCl without any food. It was observed that the resident was not eating any meals/food. Interview with Employee E9 on November 17, 2025, at 10.40 a.m. confirmed the above finding and stated the residents breakfast was over around 9:00 a.m.28 Pa. Code 211.9(a)(1) Pharmacy services28 Pa. Code 211.12 (d)(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. Based on clinical record review, review of drug information reports, observations, and interviews with staff, it was determined that the facility failed to ensure that a resident was free of a significant medication error related to the administration of Nitroglycerin tablets, which are used to treat and prevent episodes of angina (chest pain) in individuals with coronary artery disease. The medication was administered via the wrong route for one of five residents reviewed (Resident R183). Findings include:Review of FDA-approved prescribing information for Nitroglycerin sublingual tablets revealed that the medication must be administered under the tongue or in the buccal pouch for proper absorption and rapid onset of action. The FDA instructions specify that the tablet should not be swallowed, chewed, or crushed because swallowed nitroglycerin undergoes extensive first-pass metabolism in the liver, which significantly reduces the amount of active medication that enters the bloodstream. As a result, swallowing the tablet greatly decreases its effectiveness and does not provide the rapid relief required during an angina episode.Review of physician order for Resident R183 dated September 21, 2025, revealed an order for Nitroglycerin Sublingual Tablet Sublingual 0.4 MG (Nitroglycerin) Give 1 tablet sublingually as needed for Chest Pain. Observation of the morning medication pass for Resident R183 on November 17, 2025, at 10.28 a.m., with Employee E9, Licensed Practical Nurse revealed that the resident complained to the employee that he was having chest pain. Employee removed Nitroglycerin Sublingual Tablet from the cart and administered to the resident orally with water. Residents were observed swallowing the medication. Interview with Employee E9 on November 17, 2025, at 10.40 a.m. confirmed the above observation. 28 Pa. Code 211.9(a)(1) Pharmacy services28 Pa. Code 211.12 (d)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of facility policy, observation, and staff and resident interview, it was determined that the facility failed to ensure that all drugs and biologicals were stored in accordance with professional standards for 2 of 6 medication carts reviewed. (400 cart 2 and 400 split cart) Findings include: Observation of the 400-unit split cart on [DATE], at 10:22 a.m., with Employee E10, Licensed Practical Nurse, revealed an insulin vial (Degludec) with two dates written on the bottle, listed as [DATE], and [DATE]. Employee E10 could not specify which date represented the date the vial was opened.Further observation revealed a vial of insulin glargine in the cart with an opened date written as [DATE]. Employee E10 confirmed that the insulin had expired more than two months ago.Continued observation revealed a bottle of Famotidine 10 mg tablets that had expired in [DATE].Observation of the 400 cart two on [DATE], at 10:36 a.m., with Employee E11, Licensed Practical Nurse, revealed an insulin vial (Amelog) with a date written on the bottle as [DATE]. The bottle was labeled to discard the medication 28 days after opening.Further observation revealed a vial of insulin lispro with two dates written on the bottle, [DATE], and [DATE]. The instructions on the bottle indicated that the medication should be discarded 28 days after opening.28 Pa. Code 211.12(d) Nursing services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interviews, and policy review, it was determined that the facility failed to ensure staff followed proper infection control practices by not cleaning and disinfecting a blood glucose monitor after the use for one of one observation (Employee E9)Findings include:Review of the facility policy titled Glucometer Cleaning and Disinfection Policy dated October 2025 revealed: The facility will ensure blood glucometers are cleaned and disinfected after each use and according to the manufacturer's instructions for multi-resident use. The glucometers should be disinfected with a wipe pre-saturated with an EPA-registered healthcare disinfectant that is effective against HIV, Hepatitis C, Hepatitis B virus, and C. diff. Glucometers should be cleaned and disinfected before and after each use and according to the manufacturer's instructions, regardless of whether they are intended for single-resident or multi-resident use. Two (2) glucometers will be maintained on the cart to allow drying time between residents.Observation of the morning medication pass for Resident R183 on November 17, 2025, at 10:28 a.m., with Employee E9, Licensed Practical Nurse, revealed that the employee obtained the resident's blood glucose and returned the glucose monitor to the medication cart. The employee removed and discarded the test strip and then placed the monitor back in the cart. Employee E9 did not clean or disinfect the monitor.Interview with Employee E9 after the observation revealed that she did not clean the monitor because she believed it did not come into contact with blood. When asked if she knew how to properly clean the monitor, she stated that she would use small alcohol wipes, which were stored on the cart for skin preparation prior to needle sticks. Employee E9 was not aware of the required cleaning process using wipes pre-saturated with an EPA-registered healthcare disinfectant or the required drying time.28 Pa. Code 211.12(d) Nursing Services