STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395084	A. Building B. Wing	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accela Rehab and Care Center at Somerton	650 Edison Avenue Philadelphia, PA 19116

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and staff interviews, the facility failed to maintain a safe, clean, and sanitary environment in resident-use and service areas for one of two nursing units. (Second floor)Findings include: Observations on the second-floor nursing unit, conducted on December 1, 2025, at 9:15 a.m. with Licensed Practical Nurse, Employee E3, revealed that the shower room tub contained piles of dirty clothing, three razors, and a soiled brief. Continued observations revealed dirty clothing along the left side of the tub, including socks and gowns, which were touching an exposed trashcan containing soiled briefs. A follow-up observation conducted on December 1, 2025 at 9:36 a.m. with Housekeeping, Employee E4, and the facility administrator confirmed the above findings. During observations in the soiled utility room on December 1, 2025, at 9:37 a.m. conducted with Housekeeping, Employee E4, and facility administrator, revealed two exposed trashcans with overflowing trash, and a bag of soiled clothing lying on the floor. The bag was ripped, with soiled clothing falling out and touching the floor. 28 Pa. Code 207.2(a) Administrator's responsibility.

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and review of the facility documentation, the facility failed to complete a thorough investigation regarding an allegation of staff entering a resident room and searching personal belongings for one of four residents reviewed. (Resident R3)Findings include: Interview with Resident R3, conducted on December 1, 2025, at 12:00 p.m. revealed that Licensed Practical Nurse, Employee E7, entered the resident's room while the resident was not present and looked through my stuff. Continued interview revealed that when Resident R3 returned to their room, Employee E7 attempted to take the coat from the resident. Further interview revealed that the Nurse, Employee E7, had taken my coat, which was my property without explaining what is going on and that their privacy and property rights had been violated. Resident R4's roommate, Resident R2, confirmed that she witnessed Employee E7 grab Resident R2's coat. Interview with Licensed Practical Nurse, Employee E5, conducted on December 1, 2025, at 12:10 p.m. confirmed that on November 4, 2025, she had seen Employee E7 enter Resident R3's room without permission and search through the resident's items, while the resident was not present. Employee E5, who witnessed the event, reported the incident to the social worker. Interview conducted with the facility administrator and director of nursing on December 1, 2025, at 2:00 p.m. confirmed that they were made aware of the allegation mentioned above on November 4, 2025. Review of facility documentation, undated, failed to reveal resident statements from staff and either involved resident- including Resident R2, R3, and R4, which resulted in failure to determine potential misappropriation and ensure resident safety as required. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 201.29 (a) Resident rights.