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	04/14/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility polices and documents, clinical record review and interviews with staff, it was determined the facility failed to properly supervise a cognitively impaired resident who was able to exit the facility and board a train, for one of five residents reviewed for elopement risk (Resident R1). This failure placed the resident in an Immediate Jeopardy situation. Findings include:Review of facility policy, Wandering and Elopements dated March 2019, revealed The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Review of facility education module Front Door Monitoring and Access Control undated, revealed, Elopement prevention programs are required for cognitively impaired residents. Continued review revealed, Elopement is defined as a resident leaving the facility without staff knowledge or authorization. It is a serious event that can result in injury, death and regulatory citation. Continued review revealed, The front door entrance must be actively monitored at all times . Being alert to any resident who may be approaching the exit. Further review revealed that receptionist responsibilities include knowing which residents are on the unit-level elopement alert list. Review of Resident R1's admission MDS (Minimum Data Set - mandatory periodic resident assessment tool), dated March 17, 2026, revealed the resident was admitted to the facility on [DATE], and had diagnoses including Dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), Cerebrovascular accident (damage to the brain from interruption of its blood supply) and cognitive communication deficit (problems with communication due to difficulties with thinking processes). Continued review revealed that the resident had a BIMS (Brief interview for Mental Status) score of four, indicating the resident was severely cognitively impaired. Review of Resident R1's Elopement Risk Evaluation, dated March 12, 2026, revealed the resident was at risk for elopement due to history of attempting to leave the facility without informing staff; verbally expressing the desire to go home, packing belongings to go home or staying near a door; wandering with a goal directed pattern; wandering behavior that is likely to affect safety or well-being of self/others; and being recently admitted to the facility. Review of Resident R1's care plan, dated initiated March 12, 2026, revealed the resident was at risk for elopement due to history of attempts to leave the facility unattended; impaired safety awareness; removing name tag from door, and removing wander guard several times. Interventions included use of a wanderguard (device that is placed on resident's wrist or ankle which sound alarms or prevent doors from being opened for exit) and to distract the resident from wandering. Continued review of Resident R1's care plan, dated initiated March 16, 2026, revealed the resident had impaired cognitive function/dementia or impaired thought processes related to difficulty making decisions, impaired decision-making, long-term memory loss and short-term memory loss. Interventions included to cue, reorient and supervise the resident as needed. Review of Resident R1's admission note, dated March 11, 2026, at 10:11 p.m. revealed the resident had confusion upon admission to the facility with behaviors including refusals of care and wandering. Review of Resident R1's nursing note, dated March 12, 2026, at 6:44 a.m. revealed the resident was up at this time trying (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to go home. Resident redirected at this time. Continued review of Resident R1's clinical record revealed a BIMS (Brief Interview of Mental Status) evaluation completed by Employee E7, Speech Therapist, on March 12, 2026, at 9:52 a.m. Employee E7 noted that the resident had increased agitation, it is to be noted first answer 2038 for year, resident uncertain of year . resident additionally does not know where (he/she) is presently. The BIMS evaluation revealed a score of four, indicating severe cognitive impairment. Review of Resident R1's nursing note, dated March 14, 2026, at 2:50 p.m. revealed the resident had wander guard and that the resident required redirection during the shift. Review of Resident R1's eMAR note (electronic medication administration record), dated March 16, 2026, at 1:36 p.m. revealed the resident removed his/her wanderguard device. Review of Resident R1's nursing note, dated March 16, 2026, at 2:22 p.m. revealed the resident expresses comments about wanting to leave the facility, the resident often packing (his/her) things in a bag and walks to the front door, trying to reason with the staff about letting leaving, the resident has spoken to social worker, the resident was taken back to (his/her) room, wander guard is still off. Review of physician notes for Resident R1 on March 19, 20, and 21, 2026, revealed the resident was confused and requesting to discharge home. The physician assessment and plan for the resident's diagnosis of dementia included supportive care, reorientation and to monitor cognition and safety awareness. Review of Psychosocial Evaluations for Resident R1, dated March 23, 2026, revealed the mental health provider conducted a BIMS assessment and determined the resident's score was four (severe cognitive impairment). The mental health provider noted the resident has Dementia, and that cognitive impairment impacts the ability to retain information and therapeutic interventions. Review of Resident R1's Psychiatric (mental health) Evaluation and Consultation, dated March 24, 2026, revealed upon exam the resident had memory impairment, irritability, agitation, restlessness, confusion, weakness, and forgetfulness. Review of Resident R1's Social Services note, by Employee E5, Director of Social Services, on April 6, 2026, at 1:39 p.m. revealed Resident expressed desire to leave the facility and stated that if discharge does not occur today, (he/she) will attempt to leave on (his/her) own. Resident noted to have severe cognitive impairment and lacks capacity to make informed discharge decisions. Resident unable to verbalize understanding of risks associated with leaving independently. Resident redirected, however, continues to verbalize intent to leave. Physician notified. Resident will be closely monitored with implementation of least restrictive interventions due to elopement risk. Continue review revealed the resident's physician and representative were notified of resident's expressed desire to leave the facility and noted lack of decision-making capacity. Both made aware of potential elopement risk. Further review of progress notes for Resident R1 revealed a Social Services note, by Employee E5, Director of Social Services, on April 6, 2026, at 2:28 p.m., Resident left the facility without staff knowledge/authorization at approximately 2:00 p.m. Resident has a history of severe cognitive impairment and lack of capacity to make informed decisions regarding discharge. Resident had previously verbalized desire to leave the facility and intent to do so. Upon discovery of resident's absence, facility initiated immediate search of the building and surrounding area. Local police were notified via 911 (Emergency Medical Services) at 2:25 p.m. Description of resident, last known location and clothing provided to authorities. Physician and facility administration notified of incident. Attempts made to contact any known emergency contacts. Resident considered at risk due to impaired cognition and inability to ensure personal safety. Facility will continue to cooperate with authorities and monitor for resident's return. Review of information dated April 6, 2026, initially submitted by the facility on April 6, 2026, at 9:21 p.m. revealed on April 6, 2026, at approximately 2:00 p.m. nursing staff and the Director of Social Services noticed the resident was not in his/her room. Staff searched the building and surrounding area. The Maintenance Director stated that he saw the resident near the train station, but by the time he arrived, the resident was already on the train. The facility notified police and staff continued to search for the resident at train stations, shelters and hospitals. At 9:02 p.m. a local hospital was called; the hospital reported that the resident walked into their emergency department at 8:38 p.m. The resident returned to the facility on April 6, 2026, and was (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	placed on one-to-one supervision and subsequently transferred to the Veterans hospital for placement on April 7, 2026, at 8:00 p.m. Review of facility documentation, dated April 6, 2026, revealed a statement from Employee E4, receptionist, I was sitting at desk giving the xray tech room numbers when resident left the building. I was unaware that I had even let (him/her) out. Continued review of facility documentation, dated April 6, 2026, revealed a statement from Employee E8, Maintenance Director, I took a late lunch around 1:30-1:40 p.m. on my way back from leaving [local restaurant] I ?thought' I may have seen [Resident R1] at the train station sitting there. When I returned to the facility I checked in at the front desk and overheard nursing and staff talking about (him/her) missing. Reason I did not immediately stop was because I thought (he/she) was being discharged when I realized (he/she) wasn't. I immediately told them (staff) what I may have seen and then ran to my truck and drove to [local] station within one minute of leaving and arriving at station there was a train leaving and did not locate [Resident R1] in the area after that. I then drove to . station without luck and went on to all stations from there to [adjacent state]. My search concluded at 10:30 p.m. without any luck. Review of facility documentation of the timeline of events, Resident R1 left the building via the front door on April 6, 2026, at 1:42 p.m. At 2:00 p.m. the facility initiated a search for the resident. Police were notified at 2:25 p.m. The facility called a local hospital at 9:03 p.m. was informed that the resident was in the emergency room. Review of nursing notes for Resident R1 revealed the resident was readmitted to the facility from the hospital on April 7, 2026, at 3:20 a.m. Review of hospital discharge records, dated April 7, 2026, revealed the resident was assessed upon (his/her) arrival to the emergency department and was noted to be disoriented to time and place. The resident was assessed at the hospital and found to have no injuries. Observation on April 14, 2026, at 8:50 a.m. revealed Employee E4, receptionist, seated at the reception desk in the lobby. Interview, at the time of the observation, Employee E4 stated she was the one who opened the door and let the resident out. Employee E4 stated she was reviewing room numbers with an x-ray technician and wasn't looking at the door when she opened it. Employee E4 stated the elopement binder was at the desk at the time, however, she could not recall if Resident R1 was listed as an elopement risk in the binder at the time of the incident. Interview on April 14, 2026, at 1:22 p.m. Employee E5, Director of Social Services, confirmed Resident R1 had cognitive impairment and was not safe to discharge independently from the facility. Resident R1 was unable to verbalize understanding of risks associated with leaving independently and would not provide sufficient information for discharge, including discharge address. Based on the above findings, an Immediate Jeopardy to the safety of the resident was identified for failure to provide adequate supervision of a resident who was identified as an elopement risk by the facility. Resident R1 left the facility and boarded a train on April 6, 2026, at 1:42 p.m. and was located at a local hospital on April 6, 2026, at 9:03 p.m., a period of over seven hours. An Immediate Jeopardy template (document which included information necessary to establish each of the key components of immediate jeopardy) was provided to the Nursing Home Administrator (NHA) on April 14, 2026, at 2:37 p.m. On April 6, 2026, the facility initiated a plan of correction to address the failure of ensuring that a resident was adequately supervised to prevent elopement. The facility plan of correction included the following:- A thorough investigation and incident report were completed.- All staff were re-educated on elopement awareness, monitoring responsibilities, elopement drills and protocol for identifying at-risk residents.- All residents were accounted for, and a safety check of the facility was completed.- The resident's responsible party was notified.- A door chime sensor was ordered to alert the receptionist and staff any time someone enters or exits through the front door.- Doors connecting the lobby to the unit were installed- Upon the resident's return, a wander guard device was placed on the resident and verified to be in good working condition.- The resident was placed on 1:1 monitoring immediately upon return. Skin assessment completed and noted no injuries or bruises.- All residents identified as being at elopement risk had their care plans reviewed and updated and their wander guards were checked to ensure proper functioning.- The elopement binder was reviewed and updated to ensure accuracy.- The facility (continued on next page)

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