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	05/20/2026

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 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 clinical records, facility documentation, and staff interview, it was determined the facility failed to report a resident's self-injurious behavior resulting in injury requiring hospital transfer and sutures to the Department of Health for one of three residents reviewed (Resident R1).Findings include: Review of Resident R1's clinical record revealed Resident R1 was admitted to the facility on [DATE] with diagnoses including dementia (condition that causes a decline in memory, thinking, reasoning, and the ability to do everyday activities), schizoaffective disorder (mental health condition that includes symptoms of both schizophrenia and a mood disorder), and generalized anxiety disorder. Review of Resident R1's Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs), dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment. Review of Resident R1's clinical record revealed the resident was sent out and admitted to a psychiatric facility on [DATE] related to inappropriate behaviors and re-admitted to the facility on [DATE]. Documentation revealed the resident was subsequently sent back to the hospital due to increased behavioral disturbances and unsafe behaviors and returned to the facility on [DATE]. Review of Resident R1's nursing progress note, dated [DATE] at 1:10 p.m., revealed Resident observed with increase psych behaviors. Resident observed placing himself on the floor multiple times. Charge nurse walked into room and witnessed resident banging his head against the floor. (Assistant Director of Nursing and Physician) made aware and order received to send to the ER for evaluation and treatment r/t self-harm. Wound nurse in room to clean open area to right forehead and observed resident then banging his head against his siderail. Resident stated to UM, Charge nurse and wound nurse that his deceased dad and the vampires told him to do it. Resident then started howling like a wolf and was repeating I'll be good I'll be good. Review of Resident R1's nursing progress note, dated [DATE] at 6:30 p.m., revealed Resident R1 returned to the facility status post head injury and laceration, repaired with sutures, resident to follow up with PCP to remove the stitches in 3-5 days. Review of Department of Health Reporting System revealed no evidence the incident was reported to the appropriate agency. Interview on [DATE] at 10:00 a.m., with Employee E1, Administrator, confirmed the incident was not reported to the Department of Health. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.29 (a) Resident rights

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