STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025

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 0582 Level of Harm - Potential for minimal harm Residents Affected - Many	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 43277 Based on a review of clinical records, review of facility documentation, and staff interview, it was determined that facility failed to timely provide notices of Medicare non coverage (payment) for three out of three residents and failed to provide the Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN) for two out of three residents reviewed (Resident R76, R161, and R117). Findings Include: A review of the form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123, (a notice that informs the recipient when care received from the skilled nursing facility is ending; and how to contact a Quality Improvement Organization (QIO) to appeal) revealed instructions that a Medicare provider must ensure that the notice is delivered at least two calendar days before Medicare covered services end. A review of the Form Instructions Skilled Nursing Facility (SNF) Advanced Beneficiary Notice of Non-coverage (SNFABN) Form CMS-10055 revealed that examples of the common reasons why an extended care stay, or services may not be covered under Medicare might include the beneficiary no longer requires daily skilled care for a medical condition but wants to continue residing in the skilled nursing facility (SNF). The SNF enters a good faith estimate of the cost of the corresponding care that may not be covered by Medicare. In the blank that follows Beginning on ., the skilled nursing facility enters the date on which the beneficiary may be responsible for paying for care that Medicare is not expected to cover. The beneficiary selects an option box to indicate a desire to continue to receive the care or not to continue to receive the care and if there is a desire to have the bill submitted to Medicare for consideration. The beneficiary or their authorized representative must sign the signature box to acknowledge that they read and understood the notice. The SNF must issue this notice when there is a termination of all Medicare Part A services for coverage reasons. If after issuing the NOMNC, the SNF expects the beneficiary to remain in the facility in a non-covered stay, the SNFABN must be issued to inform the beneficiary of potential liability for the non-covered stay. Review of facility documentation revealed Medicare services ended for Resident 76 on February 21, 2025; Medicare services ended for Resident R161 on October 29, 2024; and Medicare services ended for Resident R117 on January 3, 2025. Resident R76 and 161 remained in the facility and Resident R117 was discharged to home. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Many	Review of the Notices of Medicare Non-Coverage (form CMS-10123) provided for Resident R76, R161, and R117 revealed the facility failed to provide the required form timely. The facility did not provide form CMS-10123 at least two calendar days before Medicare covered services ended. Continued review of documents provided by the facility revealed no documented evidence Residents R161 and R76 were provided with the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF-ABN; Form CMS-10055) to notify the residents and/or Representative of the cost of the facility's items and services no longer covered under Medicare Interview on March 13, 2025, at 10:15 a.m. with the Nursing Home Administrator, Employee E1, confirmed the NOMNC was not provided timely for Resident R76, R161, and Resident R117. Further interview confirmed the facility did not have evidence that Resident R76 and R161 were provided with the SNF-ABN Form CMS-10055. 28 Pa. Code 201.14 (a) Responsibility of licensee

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44882 Based on review of facility policy, observation, clinical record review and interview with staff/residents/family, it was determined that the facility did not ensure that privacy and confidentiality of person medical information was maintained for six of six residents reviewed (Residents R4, R122, R128, R131, R171, and R199). Findings include: Observations of the D unit conducted on March 12, 2025 at 12:30 p.m. revealed that a schedule of resident appointments for the day on the desk of the nurse's station in view of the public. Included on the schedule were the following appointments: [Resident R4] [room number] (GASTRO) PU [pick up]: 10AM, APPT: 11AM . [Resident R122] [room number] (DIALYSIS) IF READMITS 3/11/2025 [Resident R128] [room number] (EYE MEASUREMENTS) PU: 7AM APPT: 9AM . [Resident R131] [room number] (NEUROLOGY) PU: 7:30AM APPT: 9AM . [Resident R171] [room number] (DIALYSIS) [Resident R199] [room number] (METHADONE) PU: 7AM . Also included were the staff escorts for Residents R131, R128, and R199, the addresses of the locations of the appointments for Residents R4, R128, and R131, and what transportation company or other arrangements had been made to transport Residents R4, R128, R131, and R199. In an interview on March 12, 2025, at 1:00 p.m. Nurse aide, Employee E11, confirmed that resident schedules are routinely kept in plastic frame on top of the nurse's station in view of visitors and other residents. Interview with the Nursing Home Administrator on March 13, 2025, at 2:30 p.m. confirmed that this practice did not meet the expectations of privacy and confidentiality of residents' protected health information. 28 Pa. Code 201.29(i)Resident Rights 28 Pa. Code 211.12(d)(3) Nursing Services

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F 0602

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Protect each resident from the wrongful use of the resident's belongings or money.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46508

Based on review of facility policy, review of clinical records and staff interview, it was determined that the facility did not ensure that residents were free of misappropriation of resident property related to diversion of a narcotic medication for one of three residents reviewed who were prescribed narcotic medications. (Resident R416)

Findings include:

Review of Resident R416's clinical record revealed that Resident R416 was admitted to the facility on [DATE] with diagnoses of but not limited to Sepsis, Cellulitis of the Lower Limb, Anxiety Disorder

Review of Resident R416's physician's orders revealed an order for Oxycodone Acetaminophen Oral Tablet 5-325 MG (Oxycodone w/ Acetaminophen) give 1 tablet by mouth every 6 hours as needed for Moderate - Severe Pain

-Start Date-06/13/2024 with a discontinued date of 06/28/2024

Review of facility investigation on Resident R416's missing Oxycodone Acetaminophen Oral Tablet 5-325 MG

(Oxycodone w/ Acetaminophen) revealed that Resident R416 was missing 28 tablets of Oxycodone Acetaminophen Oral Tablet 5-325 MG on June 10, 2024. Further, the facility was not able to account for the missing 28 tablets of Oxycodone Acetaminophen Oral Tablet 5-325 MG.

Review of a xerox copy of Resident R416's Narcotic Accountability record revealed a number 180 on the upper right-hand corner of the page. Further the page had Resident R416's name and Oxycodone 5/APAP 5-325 1 tab. Q (every) 6 hours for pain handwritten on it. Further, the column for date and the column for time was not visible in the copy.

Further review of the xerox copy of Resident R416's Narcotic Accountability for Oxycodone Acetaminophen Oral Tablet 5-325 MG record revealed that the first line of the page did not have a date. Further under column quantity remaining was an entry of 30 tablets. Further, the column for Nurse's Signature had a signature that was not legible. The second line had a written notation of 2 wasted with an entry of 28 under the column Quantity Remaining. Further, the column for Nurse's Signature had a signature that was not legible. The third line had an entry of 1 under column Quantity on hand and a line and a word ERROR written next to it. Column Quantity Remaining was left blank (no entry). Further the page had a line written diagonally across with a notation page 154

Review of a copy of a page of the Narcotic Accountability book with Resident R416 and Diazepam 1-tab po BID (twice a day) handwritten on it revealed that the copy did not have the page number on it.

Interview with Director of Nursing (DON) Employee E2 conducted on March 11, 2025, at 11:15 AM revealed that the page that has Resident R416 and Diazepam 1 tab po BID hand written on it was page 154.

(continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further interview with DON Employee E2 revealed that the Narcotic book which contained the original record of the missing Oxycodone Acetaminophen Oral Tablet 5-325 MG, and which also contained the record signatures of the licensed nurses attesting that the narcotics were being accounted for between shifts had probably been discarded no longer available for review. However, Employee E2 confirmed that on June 9, 2024, during the 3-11 shift was when the last documented evidence that the Oxycodone Acetaminophen Oral Tablet 5-325 MG was accounted for. Review of written statement from 3-11shift Licensed nurse, Employee E12 dated June 13, 2024, revealed that on June 9, 2024, Employee E12 received 30 Oxycodone Acetaminophen Oral Tablet 5-325 MG from Employee E14. Further, Employee E12's written statement revealed that he wasted 2 Oxycodone Acetaminophen Oral Tablet 5-325 MG with Employee E14, with 28 tablets remaining. Review of Employee E14's written statement dated June 10, 2024, revealed that on June 10, 2024, during the 7-3 shift, Employee E14 counted the narcotics, and count was correct (28 tabs), at 8 am 6.10.24- resident 416 asked for Percocet. Percocet was missing, supervisor informed. Further interview with DON Employee E2 conducted on 03/11/25 11:15 AM confirmed that it was discovered that 28 tablets of Oxycodone Acetaminophen Oral Tablet 5-325 MG were missing during the 7-11 shift on June 10, 2024. Further, DON Employee E2, confirmed that on June 9, 2024, the 7-3 and the 3-11 nurse did not count the Oxycodone Acetaminophen Oral Tablet 5-325 MG together, Further, DON Employee E2 also confirmed that the 3-11 nurse and the 11-7 nurse did not count the Oxycodone Acetaminophen Oral Tablet 5-325 MG between shifts on June 9, 2024. Further DON also revealed that the 11-7 nurse and the 7-11 nurse did not count the Oxycodone Acetaminophen Oral Tablet 5-325 MG between shifts on June 10, 2024, Further interview with Employee E2 confirmed that on June 9, 2024, during the 3-11 shift was when the last documented evidence that the Oxycodone Acetaminophen Oral Tablet 5-325 MG was accounted for. Further interview with Employee E2 revealed that all licensed nurse must count the narcotics together between shifts. Further Employee E2 confirmed that the nurses did not follow facility policy regarding the accounting of narcotics. Random review of Resident R416's narcotic accountability record revealed that on June 6, 2024, there was a documented evidence that 1 tab of Oxycodone Acetaminophen Oral Tablet 5-325 was pulled but review of MAR (medication administration record) revealed no documented evidence that the Oxycodone Acetaminophen Oral Tablet 5-325 was administered to Resident R416. Further, on June 2, 2024, there was a documented evidence that 1 tab of Oxycodone Acetaminophen Oral Tablet 5-325 was pulled but review of Resident R416's MAR revealed no documented evidence that the Oxycodone Acetaminophen Oral Tablet 5-325 was administered to Resident R416. 28 Pa. Code 201.14(a)(b) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(2)(3) Management 28 Pa. Code 201.29(a) Resident rights

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 43277 Based on review of facility documentation, clinical record reviews, and interviews with staff, it was determined that the facility failed to notify the Office of the State Long-Term Care Ombudsman of facility-initiated emergency transfers as required for three of three residents reviewed for hospitalization s (Resident R171, R136, and R123). Findings Include: Review of Resident R123's clinical record revealed the resident was sent to the hospital on December 2, 2024 and December 26, 2024. Review of facility documentation revealed the facility failed to notify the Office of the State Long-Term Care Ombudsman. This was confirmed with the Nursing Home administrator on March 13, 2025 at 12:33 p.m. Review of Resident R136's Discharge Assessment- Return Anticipated MDS (Minimum Data Set, a periodic evaluation of resident needs) dated November 23, 2024, Section A Identification Information, revealed that the resident was discharged to a Short-Term General Hospital. Review of facility documentation revealed the facility failed to notify the Office of the State Long-Term Care Ombudsman of Resident R136's discharge to the hospital. Interview on March 13, 2025, with Nursing Home Administrator, Employee E1, confirmed that the facility did not notify the Office of the State Long-Term Care Ombudsman of Resident R136's discharge to the hospital as required. Review of Resident R171's clinical record revealed a nursing progress note, dated January 25, 2025, which indicated that the resident had gross involuntary jerking movements of arm, legs and twitching of the neck with altered vital signs and was subsequently transferred to a local hospital emergency department for evaluation. Review of facility documentation revealed Resident R171 was not included on the list of residents that was sent to the Office of the State Long-Term Care Ombudsman, who should have been notified of Resident R171's facility-initiated emergency transfer to the hospital. Interview on March 13, 2025, with Nursing Home Administrator, Employee E1, confirmed that the Office of the State Long-Term Care Ombudsman was not notified of Resident R171's facility-initiated emergency transfer to the hospital. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(2) Management

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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** 36609 Based on review of clinical records, facility documentation, and resident and staff interviews, it was determined that the facility failed to provide care and services in accordance with professional standards when the facility failed to ensure vital signs were obtained and hypoglycemic protocols were implemented in accordance with physcian orders for three of 35 resident records reviewed (Residents R28, R65, and R123). Findings include: Clinical record review revealed Resident R28 was admitted to the facility January 18, 2023 with a diagnosis that included but not limited to chronic kidney disease (condition where kidneys are damaged and can't filter blood properly), hypertension (high blood pressure), and peripheral vascular disease (progressive disorder that causes narrowing or blocking of the blood vessels outside the heart). Review of Resident R28's physician orders, dated February 26, 2025, revealed vital signs (blood pressure, temperature, pulse, respirations, oxygen saturation, and pain level) are to be obtained every evening shift on Tuesday, Thursday, and Saturday. Interview on March 11, 2025 at 9:35 a.m. with Resident R28 revealed Resident R23 does not recall staff obtaining his/her vitals signs every Tuesday, Thursday, and Saturday. Review of Resident R28's medication administration record (MAR) revealed from March 1, 2025 through March 10, 2025 no vital signs were documented in Resident R23's clinical record. Interview on March 11, 2025 at 9:57 a.m. with Unit Manager, Employee E10, confirmed Resident R28 did not have vitals signs documented in his/her clinical record, which indicated that vital signs were not obtained as ordered by physician. Resident R65 was admitted to the facility on [DATE] with the diagnosis of diabetes (the body does not produce enough insulin or does not use it effectively) with physcian orders for hypoglcemia (blood sugars below 70), Glucose Gel 40% Give 1 dose by mouth as needed for Low BS (blood sugar) < (less than)70 symptomatic or asymptomatic but conscious and able to swallow repeat BS (blood sugar) in 10- 15 mins. If BS is still < 70 administer again if no improvement notify MD (physician), hold all diabetic meds, including insulin and oral meds. Administer rapidly absorbed card per order. If mealtime, have patient eat meal. Repeat BS in 10-15 mins; if above 70, or ordered parameter, give diabetic meds. If below 70, repeat juice and BS measurement x1. If no improvement, notify MD. Obtain specific follow up orders regarding diabetic meds and glucose monitoring. Follow with meal or snack within 1 hour as needed for hypoglycemia. Hypoglycemia Protocol: extremely drowsy and unable to swallow perform BS if below 70 or per low parameter, immediately Administer Glucagon per Glucagon order. Remain with patient and monitor VS. Hold all diabetic meds, insulin and oral meds. As patient responds and is able to swallow, provide meal/snack of protein and starch. Notify MD to follow up orders regarding diabetic meds and BS monitoring as needed for Hypoglycemia. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of nursing progress note on January 25, 2025, indicated Resident' R65's insulin was held due to blood sugar of 65, the resident was asymptomatic and refused juice when offered. No further evidence of monitoring and/or physician notification was documented. Review of nursing progress note on January 20, 2025, indicated Resident R65's blood sugar was 60 and no further evidence of interventions or monitoring and/or physician notification was documented. Review of Resident R65 medication administration report on September 24, 2024, at 12:00 p.m., documented the insulin was held due to resident's blood sugar of 67. No further evidence of nursing interventions or monitoring and/or physician notification was documented. Review of Resident R65 medication administration report on September 20, 2024, at 5:00 p.m., documented the insulin was held due to resident's blood sugar of 67. No further evidence of nursing interventions or monitoring and/or physician notification was documented. Interview with the Director of Nursing on March 12, 2025, at 3:17 p.m. stated if a resident has a blood sugar lower than 70 follow the hypoglycemic protocol and call the physician. Resident R123 was admitted to the facility diagnosed diabetes with physician orders stating when the resident's blood sugar is below 70 nursing is to notify the physician to obtain further orders and to continue monitoring the resident. Review of Resident R123's clinical record revealed on January 18, 2025 revealed low blood sugar level of 51 at 5:15 p.m. and 46 at 9:42 p.m. (guidelines may consider any value around 50 mg/dL or lower to be severe. When blood sugar levels become too low, a person is at risk of losing consciousness, having a seizure, and falling into a coma). Continue review of Resident R123 clinical record revealed no evidence of nursing interventions nor evidence the physician was notified during Resident R123 hypoglycemic event. This was confirmed with the Director of Nursing on March 13, 2025 at 11:00 a.m. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51165 Based on review of clinical records, facility policy, observations, and staff interviews, it was determined that the facility failed to provide appropriate respiratory care related to oxygen therapy for two of three residents reviewed receiving oxygen therapy. (Resident R85, R99) Findings include: Review of the facility policy titled Oxygen Administration, revised October 2010, revealed the purpose of this procedure is to provide guidelines for safe oxygen administration. Under section preparation, verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration. Assemble the equipment and supplies as needed. Clinical record review revealed Resident R85 was admitted to the facility January 15, 2025 with a diagnoses that included but not limited to heart failure, chronic respiratory failure, and bronchiectasis (condition in which airways of the lungs remain permanently damaged and widened due to persistent infection). Review of Resident R85's physician orders, dated February 27, 2025, revealed an order for oxygen tubing to be checked and changed weekly and prn (as needed). Further directions of the physician order was to date the oxygen tubing and as needed. Observation on March 12, 2025 at 9:50 a.m. revealed Resident R85 receiving 2 liters of oxygen therapy via nasal cannula. Further observation revealed Resident R85's oxygen tubing was not dated. Interview on March 12, 2025 at 9:55 a.m. with Employee E13, Registered Nurse, confirmed Resident R85's oxygen tubing was note dated and should have been labeled with a date per physician order and facility policy. Review of Resident R99's clinical record revealed that Resident R99 was admitted to the facility on [DATE] with diagnoses of but not limited to Traumatic Brain injury and Acute Respiratory Failure. Review of Resident R99's Physician Order dated March 6, 2025 at 21:06, revealed order for Trach (Tracheostomy tube) Care: 02 (oxygen) concentrator (medical device to help you breathe) set to 6 liters per minute. Check every shift. Check every shift for SOB (shortness of breath). Review of Resident R99's care plan revised on September 15, 2024, revealed Resident 99 has tracheostomy, oxygen settings at 6 liters via trach. Review of Resident R99's Treatment Administration Record revealed staff signing that resident is receiving oxygen at 6 Liters per minute from March 6, 2025 at 11:00 PM through March 10, 2025, all shifts. Observation of Resident R99's room on March 10, 2025 at 12:50 PM revealed Resident lying in bed. Resident receiving oxygen via oxygen concentrator attached to tracheostomy tube (Trach) (goes through wind pipe to help you breathe). Oxygen concentrator was set to 5 Liters per minute. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident R99's room on March 10, 2025 at 12:51 PM revealed that Resident's oxygen concentrator had a maximum output capacity of 5 Liters per minute. Interview with Registered Nurse, Employee E6, on March 10, 2025 at 12:55PM confirmed Resident R99's oxygen set to administer 5 liter/ minute. Further confirmed incorrect oxygen concentrator connected to resident. Interview with Director of Nursing, E2 on March 10, 2025 at 12:56 revealed that facility has 2 types of concentrators, 5L concentrator and 10 L concentrator. Further interview with Employee E2 confirmed incorrect oxygen concentrator being used for Resident R99. Continued observation of Resident R99'S room on March 10, 2025 at 12:57 revealed Employee E2, Director of Nursing, exchanging the 5L (liter) oxygen concentrator for a 10L (liter) oxygen concentrator. 28 Pa. Code 211.12(d)(5) Nursing services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508 Based on observation, review of facility documents and interview with staff, it was determined that the facility failed to ensure that drug records were accurate and that an account of all controlled drugs is maintained and periodically reconciled for 2 of 3 residents reviewed (Resident R141 and Resident R416) Findings include: Review of facility policy on Controlled Substances revealed that under section Policy Statement: The facility complies with all laws and regulations and other requirements related to handling. storage, disposal, and documentation of controlled substances. [NAME] section Policy Interpretation and Implementation: #4 Access to controlled medications remains locked at all times and access is recorded. #5. The Director of Nursing Services maintains a list of personnel who have access to medication storage areas and controlled substance containers. #6. Keys to the controlled substance containers are kept in a single key ring separate from any other keys. #7. The charge nurse on duty maintains the keys to controlled substance containers. #8. Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift. Review of Resident R416's clinical record revealed that Resident R416 was admitted to the facility on [DATE] with diagnoses of but not limited to Sepsis, Cellulitis of the Lower Limb, Anxiety Disorder Review of Resident R416's physician's orders revealed an order for Oxycodone Acetaminophen Oral Tablet 5-325 MG (Oxycodone w/ Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for Moderate - Severe Pain -Start Date-06/13/2024 with a discontined date of 06/28/2024 Review of facility investigation on Resident R416's missing Oxycodone Acetaminophen Oral Tablet 5-325 MG (Oxycodone w/ Acetaminophen) revealed that Resident R416 was missing 28 tablets of Oxycodone Acetaminophen Oral Tablet 5-325 MG on June 10, 2024. Further, the facility was not able to account for the missing 28 tablets of Oxycodone Acetaminophen Oral Tablet 5-325 MG. Review of a xerox copy of Resident R416's Narcotic Accountability record revealed a number 180 on the upper right-hand corner of the page. Further the page had Resident R416's name and Oxycodone 5/APAP 5-325 1 tab. Q 6 hours for pain handwritten on it. Further, the column for date and the column for time was not visible in the copy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025

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

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F 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Further review of the xerox copy of Resident R416's Narcotic Accountability for Oxycodone Acetaminophen Oral Tablet 5-325 MG record revealed that the first line of the page did not have a date. Further under column quantity remaining was an entry of 30 tablets. Further, the column for Nurse's Signature had a signature that was not legible. The second line had a written notation of 2 wasted with an entry of 28 under the column Quantity Remaining. Further, the column for Nurse's Signature had a signature that was not legible. The third line had an entry of 1 under column Quantity on hand and a line and a word ERROR written next to it. Column Quantity Remaining was left blank (no entry). Further the page had a line written diagonally across with a notation page 154

Review of a copy of a page of the Narcotic Accountability book with Resident R416 and Diazepam 1-tab po BID handwritten on it revealed that the copy did not have the page number on it.

Interview with Director of Nursing (DON) Employee E2 conducted on March 11, 2025, at 11:15 AM revealed that the page that has Resident R416 and Diazepam 1-tab po BID hand written on it was page 154.

Further interview with DON Employee E2 revealed that the Narcotic book which contained the original record of the missing Oxycodone Acetaminophen Oral Tablet 5-325 MG, and which also contained the record signatures of the licensed nurses attesting that the narcotics were being accounted for between shifts had probably been discarded no longer available for review. However, Employee E2 confirmed that on June 9, 2024, during the 3-11 shift was when the last documented evidence that the Oxycodone Acetaminophen Oral Tablet 5-325 MG was accounted for.

Review of written statement from 3-11shift licensed nurse Employee E12 dated June 13, 2024, revealed that on June 9, 2024, Employee E12 received 30 Oxycodone Acetaminophen Oral Tablet 5-325 MG from Employee E14. Further, Employee E12's written statement revealed that he wasted 2 Oxycodone Acetaminophen Oral Tablet 5-325 MG with Employee E14, with 28 tablets remaining.

Review of Employee E14's written statement dated June 10, 2024, revealed that on June 10, 2024, during the 7-3 shift, Employee E14 counted the narcotics, and count was correct (28 tabs), at 8 am 6.10.24- resident 416 asked for Percocet. Percocet was missing, supervisor informed.

Further interview with DON Employee E2 conducted on 03/11/25 11:15 AM confirmed that it was discovered that 28 tablets of Oxycodone Acetaminophen Oral Tablet 5-325 MG were missing during the 7-11 shift on June 10, 2024. Further, DON Employee E2, confirmed that on June 9, 2024, the 7-3 and the 3-11 nurse did not count the Oxycodone Acetaminophen Oral Tablet 5-325 MG together, Further, DON Employee E2 also confirmed that the 3-11 nurse and the 11-7 nurse did not count the Oxycodone Acetaminophen Oral Tablet 5-325 MG between shifts on June 9, 2024. Further DON also revealed that the 11-7 nurse and the 7-11 nurse did not count the Oxycodone Acetaminophen Oral Tablet 5-325 MG between shifts on June 10, 2024,

Further interview with Employee E2 confirmed that on June 9, 2024, during the 3-11 shift was when the last documented evidence that the Oxycodone Acetaminophen Oral Tablet 5-325 MG was accounted for.

Further interview with Employee E2 revealed that all licensed nurses must count the narcotics together between shifts. Further Employee E2 confirmed that the nurses did not follow facility policy regarding the accounting of narcotics.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the second-floor medication room refrigerator conducted on March 11, 2025, at 9:39AM with with Director of Nursing (DON)Employees E2, Assistant Director of Nursing (ADON)Employee E4 and Unit Manager, Employee E5 revealed that an unopened vial of Lorazepam concentrates 2mg/ml labelled with Resident 141's name. Review of Narcotic Accountability Binder with Employees E2, Employee E4 and Employee E5 revealed that there was no corresponding Controlled Drug Receipt/Proof of Use/Disposition Form for the Lorazepam concentrates 2mg/ml for Resident R141. Further review of the Narcotic Accountability Binder revealed a Controlled Drug Receipt/Proof of Use/Disposition Form labelled with Resident R141's name and with Lorazepam concentrate 2mg/ml 0.5 ml (1mg) with a prescription number listed. Observation of the narcotic refrigerator and the narcotic box in the medication cart revealed that there was no corresponding lorazepam vial with a prescription number that was listed Interview with Employees E2, Employee E4 and Employee E5 conducted at the time of the observation revealed that the Lorazepam concentrates 2mg/ml with Resident 141's name could not be accounted for because there was no record of it in the narcotic book. Further, Employees E2, Employee E4 and Employee E5 also confirmed that Lorazepam concentrate 2mg/ml 0.5 ml (1mg) could not be accounted for. Further observation of the second-floor medication room refrigerator conducted on March 11, 2025, at 9:39AM with with Employees E2, Employee E4 and Employee E5 revealed fourteen vials of unopened lorazepam injection 2mg/ml in a Ziplock bag. Interview with Employees E2, Employee E4 and Employee E5 conducted at the time of the observation confirmed the 14 vials Lorazepam concentrates 2mg/ml in the refrigerator. Further Employees E2, Employee E4 and Employee E5 confirmed that the nurses across all shifts has access to the 14 vials of Lorazepam concentrates 2mg/ml but that they do not count the vials between shifts. Further, Employees E2, Employee E4 and Employee E5 revealed that the 14 vials Lorazepam concentrates 2mg/ml in the refrigerator was only counted for once every 24 hours during the day shift and that there the accounting is recorded in the pyxis. 28 Pa Code 211.9(a)(1) Pharmacy services 28 Pa Code 211.9(k) Pharmacy 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. 36609 Based on observation, interviews with resident and staff, review of clinical records and facility policy, it was determined that the facility failed to obtain physician orders to allow a resident to store a medication at bedside and further failed to ensure the medication was stored in a safe, secured location for one of 35 resident records reviewed (Resident R26). Findings include: Review of facility policy titled Self-Administration of Medications revised February 2021 states the facility will assess each resident's cognitive and physical abilities to determine whether self-administration of medication is safe and clinically appropriate for the resident. The same policy further states that self-administered medications are stored in a safe and secured place, which is not accessible by other residents. On March 13, 2025, at 9:15 a.m. the surveyor observed Resident R26's inhaler in an unsecured nightstand. Resident R26 indicated the resident had been keeping the inhaler in the resident's room, Because they (staff) can never find it. On March 13, 2025, at 3:15 p.m. the Director of Nursing stated the resident was care planned to allow the medication at bedside but was not aware there was no assessment nor that it was kept in an unlocked drawer. 28 Pa. Code 211.12(c) 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52389 Based on observation, review of facility policies, clinical record review and interviews with staff, it was determined that the facility failed to maintain an effective infection control program related to proper disposal and storage of used and potentially contaminated suctioning devices and the use of a urinary catheter tubing and drainage bag in accordance with professional standards for one of two residents reviewed. (Residents R99 and R128). Findings include: Review of facility policy, Suctioning the Lower Airway (Endotracheal [ET] or Tracheostomy Tube) revised October 2010, revealed in section General Guidelines part 31, disconnect catheter from tubing. Wrap catheter around gloved hand. Pull the glove off and over the catheter. Discard in designated receptacle. Review of Resident R99's clinical record revealed that Resident R99 was admitted to the facility on [DATE] with diagnoses of but not limited to Traumatic Brain Injury and Acute Respiratory Failure. Review of Resident R99's clinical record revealed physician order dated March 6, 2025 at 10:11 PM, Trach (Tracheostomy tube) care: suctioning every shift and as needed. Review of Resident R99's care plan revised on September 15, 2024, revealed Resident 99 has tracheostomy and interventions include suction as ordered and suction as necessary. Review of Resident R99's MDS (Minimum Data Set) Section O- Special Treatments, Procedures, and Programs, dated February 15, 2025, resident requires suctioning while a resident at the facility. Observation of Resident R 99's room on March 10, 2025 at 11:07 AM revealed resident's open suctioning catheter being stored in resident's bedside table drawer. Upon further observation, open yankhauer suction tip (an oral suctioning tool), open toothbrush, open DeClogger for enteral feeding tube (flexible tube to declog feeding tube) also stored in resident's bedside table. Interview with Registered Nurse, Employee E6, on March 10, 2025 at 11:10 AM confirmed findings of used disposable suctioning devices in Resident R 99's bedside table drawer. Interview with Director of Nursing, Employee E6, on March 10, 2025 at 11:18 AM confirmed improper storage and disposal of devices in Resident 99's bedside table drawer. Observation of Resident R 99's room on March 12, 2025 at 11:51 AM revealed that open suction catheter being stored in resident's bedside table drawer. Interview with Unit Manager, Employee E5, on March 12, 2025 at 11:53 AM confirmed finding of suction catheter improperly stored in resident's bedside table drawer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy Catheter Care, Urinary, revised September 2014, revealed under Infection Control part 2B, be sure the catheter tubing and drainage bag are kept off the floor. Review of Resident R 128 clinical record revealed that Resident was admitted to the facility on [DATE] with diagnoses of but not limited to Metabolic Encephalopathy (a change in how your brain works) and Cognitive Deficit (impairment in an individual's mental processes). Review of Resident R 128's clinical record revealed physician order dated March 1, 2025 at 3:00 PM, for urinary catheter: Foley catheter 14 FR with 10cc balloon (size of catheter) for diagnosis obstructive uropathy (obstructed urinary flow). Notify MD when foley catheter occluded or leaking. Observation of Resident R 128's room on March 10, 2025 at 10:56 AM revealed resident sleeping in bed and urinary catheter drainage bag touching floor. Interview with Registered Nurse, Employee E6 on March 10, 2023 at 11:03 AM confirmed finding of catheter drainage bag touching floor. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52389 Based on observation and resident and staff interview, it was determined that the facility failed to provide a sanitary and comfortable environment for 2 of 10 residents. (R130 and R160) Findings include: Review of R160's clinical record revealed the Resident was admitted to the facility on [DATE] with diagnoses of but not limited to Surgical Amputation (removal of a body appendage). Review of R160's MDS (Minimum Data Set) Section C- Cognitive Problems, dated February 3, 2025, revealed that the Resident has a BIMS (Brief interview for metal status) score of 15 (intact cognitive response). Observation of Resident R160's room on March 11, 2025 at 10:35 AM, revealed mouse droppings by baseboards of resident's room between head of resident's bed and night stand. Interview with Resident R160 on March 11, 2025 at 10:35 AM revealed that room cleanliness is an ongoing concern, room has not been cleaned properly since resident was admitted . Staff has been made aware of mouse droppings, however has not been cleaned up. Bed and furniture never get moved to clean. Interview with Registered Nurse, Employee E6 on March 11, 2025 at 10:40 AM, confirmed mouse droppings in Resident's room along baseboards between bed and nightstand. Stated she would request someone to clean it up. Interview with Resident R160 on March 12, 2025 at 09:45 AM revealed that residents room had not been cleaned. Observation of Resident R160'S room on March 12, 2025 at 09:40 AM revealed mouse droppings in Resident's room remain in same places along baseboards. Interview with the Nursing Home Administrator, Employee E1 on March 12, 2025 09:40 AM confirmed mouse dropping in resident's room along baseboards. Review of R130's clinical record revealed that Resident R130 was admitted to the facility on [DATE],, 2023, with diagnoses of but not limited to Opioid Abuse, Pleural effusion (buildup of fluid in lungs), and Pneumonia (infection in lungs). Observation of Resident R 130's room on March 11, 2025 at 10:46 AM revealed mouse droppings beside the resident's dresser, between a bottle of water and a bag of resident's personal belongings. Interview with Certified Nursing Assistant, Employee E7 on March 11, 2025 at 10:48 AM confirmed mouse droppings in resident R130's room beside the resident's dresser. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident R130's room on March 12, 2025 at 9:40AM revealed mouse dropping remain in same place beside the resident's dresser. Follow up observation on March 12, 2025 at 09:40 AM of Resident R130's room completed with Administrator, Employee E1 confirmed mouse droppings beside the resident's dresser, between a bottle of water and a bag of resident's personal belongings. Review of Facility's Quality Assurance Performance Improvement System Compliance Plan dated February 27, 2025 revealed an identified concern of deep cleaning of rooms in building, with a goal of continuous follow up on deep cleaning of rooms. Interview with Housekeeper, Employee E9, on March 12, 2025 at 2:20PM revealed she has never seen the rooms deep cleaned. Housekeeper does daily cleaning of rooms but does not move furniture or beds to clean around them. Interview with Housekeeping Supervisor, Employee E8, on March 13, 2025 at 11:55AM there is a schedule for deep cleaning rooms that Housekeepers follow, otherwise daily housekeeping is done. Further interview revealed the second floor is shorthanded on housekeepers. 28 Pa. Code 201.14 (a) Responsibility of licensee.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277 Based on review of facility policy, observations, and staff and resident interviews it was determined that the facility failed to maintain an effective pest control program for one of five nursing units (2nd floor). Findings include: Review of facility policy Pest control revised May 2008, revealed policy statement of Our facility shall maintain an effective pest control program. Under section Policy Interpretation and Implementation, Part 1, This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. Review of R160's clinical record revealed the Resident was admitted to the facility on [DATE] with diagnoses of but not limited to Surgical Amputation (removal of a body appendage). Review of R160's MDS (Minimum Data Set) Section C- Cognitive Problems, dated February 3, 2025, revealed that the Resident has a BIMS (Brief interview for metal status) score of 15 (intact cognitive response). Observation of Resident R 160's room on March 11, 2025 at 10:35 AM, revealed mouse droppings by baseboards of resident's room, between head of resident's bed and night stand. Interview with Registered Nurse, Employee E6 on March 11, 2025 at 10:40 AM, confirmed mouse droppings in Resident's room along baseboards between bed and nightstand. Interview with Resident R 160 on March 11, 2025 at 10:35 AM revealed that resident sees mouse running around his room and in the hallway all the time especially at night time when things quiet down. Resident reports that he has made the staff aware. Follow up interview of Resident R160 on March 12, 2025 at 09:45 AM revealed that mouse had been seen the night before and it was reported to the staff. Interview with Administrator, E1 on March 13, 2025 at 09:29 AM revealed that staff should document on Customer Complaint Record Log, which is kept at nursing station, when a concern is reported. Further interview confirmed, no report made and no documented evidence that pest control is aware of Resident R130's complaint or evidence of mouse droppings in resident rooms on 2nd Floor. 28 Pa. Code 201.14 (a) Responsibility of licensee.