

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395173	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Westgate Hills Rehabilitation and Nursing Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 2050 Old West Chester Pike Havertown, PA 19083	

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)
<p>F 0910</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure resident rooms meet each resident's needs.</p> <p>Based on observations and interviews with staff, it was determined that the facility failed to provide a safe environment for 1 of 3 residents reviewed (Resident 1). Observations made on November 21, 2025, of rooms on the Rehabilitation Unit revealed Resident 1's room had a window with broken glass pieces taped with duct tape. Further observations revealed broken pieces of glass were sitting between the glass panel and the screen. Observations made of Resident 1's room also revealed a dresser with two broken drawer fronts. The pieces were sitting inside of the drawers. Observations conducted with the Director of Nursing (DON) on November 21, 2025, at 1:07 p.m., when the above information was presented, the DON confirmed the glass and dresser drawers were broken. 28 Pa. Code 201.14 (a) 28 Pa. Code 201.18 (b)(1)(e)(1) (2.1)</p>

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
---	-------	-----------