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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395334	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Hill Lodge Health and Rehab Ctr	8833 Stenton Avenue Wyndmoor, PA 19038

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on review of facility policy, clinical records, facility documentation and interview with staff, it was determined the facility failed to ensure timely notification to the physician of fall incident sustained by Resident R1. This failure resulted in actual harm to Resident R1 who experienced a delay of treatment after a fall in the shower room with injuries, requiring transfer to the hospital and diagnoses of subdural hematoma, left zygomatic fracture, and acute right 3rd - 4th rib fractures for one of four residents reviewed. This deficiency is being cited as past non- compliance. (Resident R1) Findings include: Review of facility policy titled, ?Change of Condition' revised June 28, 2023, revealed, if the nurse aide (CNA) identifies a change in resident's condition, they will immediately notify the nurse of the situation, and the resident, attending physician and resident representative, if applicable, will be notified promptly of a significant change in condition, accident/incident, change in treatment, and/or transfer/discharge. Review of facility policy titled, ?Falls Prevention and Management' revised January 12, 2023, revealed the interdisciplinary team identifies and implements appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence. Determining casual factors leading to a resident fall is necessary to provide consistent intervention to help prevent further occurrences. Continued review of same policy revealed, in the event a resident has fallen and/or is found on the ground, a complete head to toe assessment must be performed. Resident is not to be moved until assessed for injury by an RN (Registered nurse) unless life-threatening situation exists. Remain with the resident while calling for assistance, if at all possible. If the resident is unconscious, has difficulty breathing or a severe injury is suspected, immediately call 9-1-1 (Emergency Medical Services) for transfer. Review of Resident R1's clinical record revealed medical history of traumatic hemorrhage of cerebrum (subsequent encounter), altered mental status, Cerebral Infarction (stroke) due to embolism (obstruction of an artery, typically by a clot of blood) of left cerebellar artery, age-related Osteoporosis (decreased bone density), muscle wasting and Encephalopathy (general term for brain disease, damage, or dysfunction, resulting in altered mental state, confusion, personality changes, and potential coma), mobility and gait abnormalities, Dementia (progressive degenerative disease of the brain), restlessness and agitation, Paranoid Personality Disorder, and muscle weakness. Review of Resident R1's physician orders revealed an order, initiated December 20, 2025, for 1:1 (one resident to one staff) monitoring secondary to falls, every shift. Review of Resident R1's Minimum Data Set (MDS- assessment of resident's care needs) completed on December 25, 2025, revealed Resident R1 required partial/moderate assistance for tub/shower transfer: helper does more than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. Continued review of resident's MDS revealed that the resident was assessed with a BIMS (Brief Interview of Mental Status) of 3 which indicated the resident was severely cognitively impaired. Review of Resident R1's care plan initiated November 13, 2024 revealed care plan developed for fall related to episodes of confusion which include interventions of 1:1 nursing supervision at all times, visual cues will be added to resident's room to encourage the use of the call bell, anticipate and meet resident's needs, ensure call light is within reach and keep frequent used items within reach, Review of Resident R1's (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 0580 Level of Harm - Actual harm Residents Affected - Few	nursing notes dated February 7, 2026, (9:42 p.m.) revealed the resident was noted with left side facial swelling and bruising and nosebleed from the left nostril. Pressure was applied to left nostril to stop the bleeding. The resident was not complaining of pain when (her/his) face was touched. An order was obtained to send the resident to the emergency room. 9-1-1 (Emergency Medical Services) was called and Resident R1 was transported to the hospital for evaluation. Continued review of Resident R1's nursing notes dated February 7, 2026, (9:18 p.m.) revealed Resident observed lying on the couch as EMT's (Emergency Medical Technician) arrived to pick resident up. Observed resident with swelling and bruising over the left mandibular (lower jaw). Area feels tender with no complaints or signs of pain observed or verbalized by resident. Resident unable to tell this writer what happened to (her/his) face Unable to assess the rest of (her/his) body as resident was leaving to go to the hospital. Resident was able to stand up with minimal assist onto the stretcher, guardian notified by shift supervisor. Left for [local hospital]. Review of facility documentation submitted to the State Survey Agency on February 7, 2026, revealed Resident R1 was observed with swelling and bruising on the left side of (her/his) face by nursing supervisor. The physician was called and gave order to send the resident to the hospital for further evaluation. The resident was sent to the hospital via 911 (Emergency Medical Services). Resident R1 has imaging done in the ER (emergency room) which revealed a subdural hematoma (collection of blood in the brain), left zygomatic fracture (a break in the cheekbone). Review of facility provided investigation report related to fall incident sustained by Resident R1 during evening shift on February 7, 2026, revealed Resident R1 sustained a subdural hematoma (collection of blood in the brain), left zygomatic fracture (a break in the cheekbone), and acute right 3rd - 4th rib fractures. Review of statement completed by Nurse aide, Employee E1, who was assigned to Resident R1 for continuous 1:1 supervision on February 7, 2026 evening shift, revealed I didn't see (her/him) fall, I saw the swollen and the bruise on the left side of the face, after dinner. I did not look at face. Review of additional statement completed by Nurse aide, Employee E1 dated February 9, 2026, revealed at 4:15 p.m. on February 7, 2026, I took (her/him) in the shower room, shower (her/him). After taken (her/him) from the shower chair (she/him) slip and fall on (her/his) left side and I was on (her/his) right side. I did not see any injury. I took (her/him) in the dining room and (she/him) went to sleep on the couch or chair. Review of investigation statement completed by Nurse aide, Employee E3, on February 7, 2026, revealed at approximately 6:00 pm, Resident R1 was noted with nosebleed in dining area of memory care unit; Employee E3 brought the resident to the nurses' station, informed the licensed nurse and nurse aide of Resident R1's nosebleed. Interview with Licensed nurse, Employee E2, who had oversight of memory care unit during evening shift on February 7, 2026, revealed that she was not aware of Resident R1's facial swelling, bruising and/or bleeding until 7:30 p.m. when Nursing Supervisor, Employee E4 notified her. Further review of investigation report revealed, Nursing Supervisor, Employee E4 arrived on the memory care unit, February 7, 2026, for her 7 p.m. shift. While doing rounds approximately 7:15 p.m., she noticed Resident R1 sitting in the dining room with significant facial swelling, bruising, and bleeding, including a swollen left eye and blood from the mouth. Further review of Nursing Supervisor, Employee E4's statement revealed the nurse aide assigned to the Resident R1's 1:1 monitoring, (Employee E1), alleged she did not know what happened to the resident. When Employee E4 asked the agency charge nurse, Employee E2, about the injuries, the nurse responded angrily and told Employee E4 to ask Employee E1, indicating she had 30 residents to oversee. Continued review of Employee E4's statement revealed, Employee E4 questioned why the nurse had not noticed the injuries after giving the resident medication earlier. The discussion escalated into an argument about responsibility for assessing residents and reporting possible abuse or injuries. Nursing supervisor, Employee E4 then removed the agency nurse from the building and contacted local police and the Director of Nursing regarding Resident R1's injuries. Continued review of Nursing Supervisor, Employee's E4 statement the Nursing supervisor, Employee E4 re-assessed the resident, whose nose continued to bleed, and contacted the Nurse Practitioner (NP). The NP instructed Employee E2 to call 911 (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	(Emergency Medical Services) and send the resident to the hospital for evaluation. Review of interview statement from the Nursing Home Administrator (NHA), Employee E7 on February 9, 2026, at 1:35 pm, revealed the NHA asked Nurse aide, Employee E1 to explain what happened while she was providing one to one (1:1) care to Resident R1. Nurse aide, Employee E1 initially said there was no incident. NHA informed Nurse aide, Employee E1 that Resident R1 had reported, through an interpreter, that she fell because the floor was slippery. NHA also stated that Nursing aide, Employee E3 noticed Resident R1's nose bleeding around 6:00 PM and took Resident R1 for evaluation. Nursing Home Administrator reminded Nurse aide, Employee E1 that her responsibility during the Sunday 3 PM shift was to closely watch Resident R1 on a 1:1 basis to prevent a fall. Further review of written statement of an interview conducted between the NHA and Nurse aide, Employee E1 revealed that Nursing Home Administrator confronted Nurse aide, Employee E1 because he believed something had happened to Resident R1 during Nurse aide, Employee E1's 1:1 supervision of Resident R1. During the NHA's follow up interview with Nurse aide, Employee E1 it was revealed during the interview that Nurse aide, Employee E1 admitted that Resident R1 slipped and fell while getting up from a shower chair. Employee E1 stated that Resident R1 did not appear to be in pain, so she helped dry the resident and took (her/him) to the dining room for dinner. Nurse aide, Employee E1 explained she did not report the incident because she was afraid, she would get into trouble. Interview conducted on March 10, 2026, at 2:00 p.m. with the Director of Nursing, Employee E8 and Nursing Home Administrator Employee E7 confirmed nurse aide, Employee E1 failed to notify licensed nursing staff of Resident R1's fall and injuries sustained by the resident. This deficiency was identified as actual harm past non-compliance for Resident R1 experiencing a delay in treatment after sustaining a fall in the shower room with injuries, requiring transfer to the hospital and diagnoses of subdural hematoma, left zygomatic fracture, and acute right 3rd - 4th rib fractures. The facility presented documentation indicating that the facility initiated a plan of correction to address the failure of the facility to provide timely notification after a fall sustained by resident. The facility alleged a date of compliance of February 9, 2026. The plan of correction stated the following: -On 2/27/2026 on 2/7/26 at approximately 7pm Resident R1 was noted to have swelling and bruising on the left side of (his/her) face by nursing supervisor, The supervisor asked the aide (Employee E1) what happened but aide indicated she didn't know. The DON was made aware and investigation was immediately started. Resident R1 was sent to the ER (Emergency Room) for Evaluation.-At approximately 10:30 pm the DON received a call from the hospital stating Resident R1 had a fracture of the mandible and 2 fractured right ribs and chronic subdural hemorrhage.The 1-1 aide assigned to Resident R1 at the time was suspended pending investigation. The police were contacted and came to the facility. 2/7/2026 In-servicing was started on abuse and reporting of incidents and accidents 2/9/2026- Head to toe skin and body checks were completed and all the resident residing on the Unit that Resident R1 resides. Interviews were also conducted with residents that could be interviewed to rule out abuse. 2/9/2026- Employee E1 was called in again to be interviewed regarding this resident since she was the 1-1 and nothing was noted prior to her taking over the 1-1 assignment. After lengthy discussion Employee E1 admitted that Resident R1 fell in the shower room, she stated she was afraid to report the fall.Employee E1 was educated on reporting of any incident and accidents.Employee E1 was terminated for failure to report and incident/accident.In-servicing- continued in the building to all staff on reporting falls and abuse and reporting abuse. Competencies were also given to staff after the education was done abuse.An audit of the last 2 weeks of nurse's notes and shift reports was conducted to ensure any accidents/incidents were reported per policy.The DON/ Designee will audit nurses' notes and shift reports to ensure any accidents and incidents were reported with the appropriate follow up action completed. Audits will be conducted weekly x 4 weeks and then monthly x2. Results of these audits will be submitted to QAPI to determine if further action is needed. Facility educated staff on types of abuse and reporting abused upon learning or hearing of abuse towards a resident and that every employee is expected to report it as soon as possible. Facility education (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	record and subsequent audits were verified for completion. Skin checks documentation was reviewed and completed. Facility provided evidence of audits of nurses' notes for accidents/incidents and abuse audit of non-interviewable residents. Staff were interviewed to verify education. QAPI (Quality Assurance Improvement Plan) records reviewed to verify ongoing monitoring. No continuing concerns were identified through record review, interview or observation. This deficiency was cited as past non-compliance. 28 Pa Code 201.18 (b)(1) Management 28 Pa Code 211.10(d) Resident care policies 28 Pa Code 211.12(c)(d)(1)(3)(5) nursing services

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on review of facility policy, clinical records, facility documentation and interview with staff, it was determined the facility failed to ensure that Resident R1 was free of neglect. This failure resulted in actual harm to Resident R1 who sustained a fall in the shower room with resulting physical injuries; delay in timely assessment and medical treatment for one of four residents reviewed. This deficiency was cited as past non compliance,(Resident R1)Findings include: Review of facility policy ?Falls Prevention and Management,' revised January 12, 2023, indicated that the interdisciplinary team identifies and implements appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence. Determining casual factors leading to a resident fall is necessary to provide consistent intervention to help prevent further occurrences. Continued review of the policy revealed that in the event a resident has fallen and/or is found on the ground, a complete head to toe assessment must be performed. Resident is not to be moved until assessed for injury by an RN (Registered nurse) unless life-threatening situation exists. Remain with the resident while calling for assistance, if at all possible. If the resident is unconscious, has difficulty breathing or a severe injury is suspected, immediately call 9-1-1 (Emergency Medical Services) for transfer. Review of Resident R1's clinical record revealed medical history of traumatic hemorrhage of cerebrum (subsequent encounter), altered mental status, cerebral infarction due to embolism (obstruction of an artery, Typically by a clot of blood) of left cerebellar artery, age-related osteoporosis (decreased bone density), muscle wasting and encephalopathy (general term for brain disease, damage, or dysfunction, resulting in altered mental state, confusion, personality changes, and potential coma), mobility and gait abnormalities, dementia (progressive degenerative disease of the brain), restlessness and agitation, paranoid personality disorder, and muscle weakness. Review of physician orders revealed an order obtained December 20, 2025, for 1:1 (one to one staff) monitoring secondary to falls, every shift. Review of Resident R1's Minimum Data Set (MDS- assessment of resident's care needs) completed on December 25, 2025, revealed Resident R1 required partial/moderate assistance for tub/shower transfer: helper does more than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. Continued review of resident's MDS revealed that the resident was assessed with a BIMS (Brief Interview of Mental Status) of 3 which indicated that the resident was cognitively impaired. Review of Resident R1's care plan initiated November 13, 2024, revealed a care plan developed for fall related to episodes of confusion which include interventions of 1:1 nursing supervision at all times. Review of facility documentation submitted to the State Survey Agency on February 7, 2026, revealed that Resident R1 was observed with swelling and bruising on the left side of (her/his) face by nursing supervisor. The physician was called and gave order to send the resident to the hospital for further evaluation. The resident was sent to the hospital via 911 (Emergency Medical Services). Resident R1 has imaging done in the ER (emergency room) which revealed a subdural hematoma (collection of blood in the brain), left zygomatic fracture (a break in the cheekbone). Review of investigation report revealed that Nursing supervisor, Employee E4 arrived to memory care unit on February 7, 2026, for her 7 PM shift. While doing rounds around 7:15 PM, she noticed Resident R1 sitting in the dining room with significant facial swelling, bruising, and bleeding, including a swollen left eye and blood from the mouth. Continued review of the Nursing supervisor, Employee E4's statement revealed that the nurse aide assigned to the resident's 1:1 monitoring, (Employee E1), said she did not know what happened to the resident. When Employee E4 asked the agency charge nurse, Employee E2, about the injuries, the nurse responded angrily and told her to ask Employee E1, stating she had 30 residents to manage. Nursing supervisor, Employee E4 questioned why the nurse had not noticed the injuries after giving the resident medication earlier. The discussion escalated into an argument about responsibility for assessing residents and reporting possible abuse or injuries. Nursing supervisor, Employee E4 then removed the agency nurse from the building and (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	contacted the local police and the Director of Nursing. Continued review of Nursing Supervisor, Employee E4's statement noted that after the agency charge nurse, Employee E2 left the facility, the Nursing supervisor, Employee E4 re-assessed the resident, whose nose continued to bleed, and contacted the Nurse Practitioner (NP). The NP instructed Employee E2 to call 911 (Emergency Medical Services) and send the resident to the hospital for evaluation. Review of the written statement by Nurse aide, Employee E1, who was assigned to Resident R1 for continuous 1:1 supervision on February 7, 2026, during the evening shift. I didn't see (her/him) fall, I saw the swollen and the bruise on the left side of the face, after dinner. I did not look at face. Review of interview statement from the Nursing Home Administrator (NHA), Employee E7 on February 9, 2026, at 1:35 pm, revealed the NHA asked Nurse aide, Employee E1 to explain what happened while she was providing one to one (1:1) care to Resident R1. Nurse aide, Employee E1 initially said there was no incident. NHA informed Nurse aide, Employee E1 that Resident R1 had reported, through an interpreter, that she fell because the floor was slippery. NHA also stated that Nursing aide, Employee E3 noticed Resident R1's nose bleeding around 6:00 PM and took Resident R1 for evaluation. Nursing Home Administrator reminded Nurse aide, Employee E1 that her responsibility during the Sunday 3 pm shift was to closely watch Resident R1 on a 1:1 to prevent a fall. Further review of written statement of the interview conducted between the NHA and Nurse aide, Employee E1 revealed that Nursing Home Administrator confronted Nurse aide, Employee E1 on February 9, 2026 because he believed something had happened to Resident R1 during Nurse aide, Employee E1's 1:1 supervision. Nurse aide, Employee E1, admitted during interview that Resident R1 slipped and fell while getting up from a shower chair. Employee E1 stated that Resident R1 did not appear to be in pain, so she helped dry the resident and took (her/him) to the dining room for dinner. Nurse aide, Employee E1 explained she did not report the incident because she was afraid, she would get into trouble. Further review of the documentation submitted to the State Survey Agency of the investigation of possible neglect sustained by Resident R1, revealed that the facility substantiated the allegation of neglect due to nurse aide, Employee E1 failure to report the fall incident to the nurse. Nurse aide, Employee E1 was terminated for failure to report an accident/incident involving Resident R1. Interview conducted on March 10, 2026, at 2:00 p.m. with the Director of Nursing, Employee E8 and Nursing Home Administrator Employee E7 confirmed that nurse aide, Employee E1 failed to notify licensed nursing staff of Resident R1 fall incident and injuries sustained by the resident. The facility presented documentation indicating that the facility initiated a plan of correction to address the failure of ensuring timely notification to the physician of a fall incident sustained by Resident R1, which resulted in actual harm to Resident R1 who experienced a delay of treatment after the fall incidents with injuries. The facility alleged a date of compliance of February 9, 2026. The plan of correction stated the following: -On 2/27/2026 on 2/7/26 at approximately 7pm Resident R1 was noted to have swelling and bruising on the left side of her face by nursing supervisor, The supervisor asked the aide (Employee E1) what happened the aide state she didn't know. The DON was made aware and investigation was immediately started. Resident ER1 was sent to the ER for Evaluation.-At approximately 10:30 p.m. the DOB received a call from the hospital stating the Resident R1 had a fracture of the mandible and 2 fractured right ribs and chronic subdural hemorrhage.-The 1-1 aide assigned to this resident at the time was suspended pending investigation. The police were called and came to the facility. 2/7/2026 In-servicing was started on abuse and reporting of incidents and accidents 2/9/2026- Head to toe skin and body checks were completed and all the resident residing on the Unit that Resident R1 resides on. Interviews were also conducted with residents that could be interviewed to rule out abuse. 2/9/2026- Employee E1 was called in again to be interviewed regarding this resident since she was the 1-1 and nothing was noted prior to her taking over the 1-1 assignment. After lengthy discussion Employee E1 admitted that Resident R1 fell in the shower room, she stated she was afraid to report the fall.Employee E1 was educated on reporting of any incident and accidents.Employee E1 was terminated for failure to report and incident/accident.In-servicing- continued in the building to all staff on reporting falls and abuse (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	and reporting abuse. Competencies were also given to staff after the education was done abuse.An audit of the last 2 weeks of nurse's notes and shift reports was conducted to ensure any accidents/incidents were reported per policy.The DON/ Designee will audit nurses' notes and shift reports to ensure any accidents and incidents were reported with the appropriate follow up action completed. Audits will be conducted weekly x 4 weeks and then monthly x2. Results of these audits will be submitted to QAPI to determine if further action is needed. Facility education record and subsequent audits were verified for completion. Skin checks documentation was reviewed and completed. Facility provided evidence of audits of nurses' notes for accidents/incidents and abuse audit of non-interviewable residents. Staff were interviewed to verify education. QAPI (Quality Assurance Improvement Plan) records reviewed to verify ongoing monitoring. No continuing concerns were identified through record review, interview or observation. This deficiency was cited as past non-compliance. 28 Pa Code 201.18 (b)(1) Management 28 Pa Code 211.10(d) Resident care policies 28 Pa Code 211.12(c)(d)(1)(3)(5) Nursing services