

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395334	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Chestnut Hill Lodge Health and Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on review of clinical records, facility schedules, staff interviews, and observations, it was determined that the facility failed to ensure residents were provided bathing and showering services in accordance with their assessed needs and physician orders for six of eight residents reviewed. (Residents R33, R43, R174, R164, R185, R180) Findings include: Review of facility policy titled ADL Care Bathing (shower, tub, bed, perineal) last reviewed March of 2025, revealed that the facility requires residents be offered bathing or showering at least weekly, based on resident preference and care plan orders. The policy further requires that refusals, missed care, or barriers to providing ADL services be documented and reported to licensed nursing staff. The facility failed to follow its own policy by not offering scheduled showers, inaccurately reporting resident refusals, and failing to document missed care or resident preferences. Review of facility shower schedules and ADL (activities of daily living) documentation for the CD Nursing Unit revealed multiple residents were scheduled to receive showers during the 7:00 a.m. to 3:00 p.m. shift on December 29, 2025, including Residents R172, R43, R174, R164, R185, R69, and R180. Documentation did not reflect that showers were completed as scheduled, nor did it contain documented refusals or clinical justifications for missed care. Observation of the CD Nursing Unit shower room at approximately 11:45 a.m. on December 29, 2025, revealed the shower room was completely dry and being used for storage of floor lifts. There was no evidence that the shower room had been used for resident bathing on that date. During an interview conducted with the Licensed nurse Unit Manager E9, on December 29, 2025, at approximately 11:50 a.m., the surveyor was provided with the shower schedule indicating residents were assigned to receive showers that morning on the 7:00 a.m. to 3:00 p.m. shift. Interview with Nurse aide, Employee E10 on December 29, 2025 at approximately 12:05 p.m. revealed she was preparing to provide Resident R174 with a bed bath at the time of interview and the other residents declined a shower today. Interview with Nursing Aide, Employee E11 at 12:10 p.m. revealed all residents refused showers, and that one resident could not be showered due to having a PICC (central venous) line. Resident interviews contradicted staff statements as follows: Interview with Resident R33 on December 29, 2025, at approximately 11:00 a.m. revealed the resident had not received a shower since admission to the facility three weeks prior. Interview with Resident R43 revealed the resident wanted a shower, had not refused, and stated she was never asked or offered a shower. Interview with Resident R174 revealed the resident wanted to be bathed; during the interview, a CNA was preparing to provide a bed bath. Interview with Resident R164 revealed the resident wanted a shower and stated she had never received one since admission. Interview with Resident R185 revealed the resident wished to receive a shower. Interview with Resident R180 revealed the resident wanted a shower and stated she was never asked or offered one. The resident reported washing herself with wipes due to not being provided shower assistance. 28 Pa. Code 201.20 (a)(5)(6)(b) Staff development 28 Pa. Code 211.12(d)(1)(2)(5) Nursing Services		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 395334	If continuation sheet Page 1 of 13

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of personnel files, facility documentation, policy review and interviews with staff, it was determined that the facility failed to ensure that nursing staff possessed the required licensure and certifications for three of three employees reviewed. (Employee E13, Employee E14, Employee E15) Findings include: Review of Facility contract with nursing staffing agency, titled Schedule A Statement of work (SOW) #1 dated [DATE], under section 1. Services d. It is understood and agreed by Facility [nursing staffing agency] only refers candidates for consideration and that the hiring decisions and determinations of suitability, employment eligibility verification and conditions of employment are ultimately the responsibility of Facility. Review of Employee E13's personnel file revealed that Employee E13 was agency employee, hire date of [DATE], working as a Supervisor Registered Nurse. Review of facility investigation revealed on [DATE], it was reported to facility leadership that Employee E13's nursing license was suspended on [DATE]. Interview with Employee E2, Director of Nursing confirmed that upon checking the license verification system on [DATE], it was confirmed that Employee E13's registered nursing license was suspended on [DATE]. Further interview with Employee E2, Director of Nursing, confirmed that Employee E13 worked 19 shifts between [DATE] and [DATE] in the role of Supervisor Registered Nurse. Interview with Employee E2, Director of Nursing on [DATE] at 10:25am revealed that nurses and staff accepted to work in facility nursing staffing agency have all required documentation (license, background checks, etc) loaded into a portal for facility to review and if a nurse unknown to the facility then Director of Nursing will usually confirm license verification via the State Licensing online system. Interview with Employee E1, Nursing Home Administrator on [DATE] at 10:30am revealed that prior to referenced incident, employee licenses and certifications were audited annually as a part of the mock survey process. After referenced incident, facility started new policy for HR Director to maintain a file with a 3 month look ahead with license/ certification expiration dates. However, it did not include agency staff. There was no documented evidence that facility independently verified Employee E13's registered nursing license. Review of Employee E14's personnel file revealed that the employee was full-time employee, hire date of [DATE], working as a nursing Aide. Review of facility investigation revealed that Employee E14, nurse aide certification expired on [DATE]. Interview with Employee E1, Nursing Home Administrator on [DATE] at 10:30am confirmed that Employee E14 remained fulltime in facility between [DATE] and [DATE]. Review of Employee E15's personnel file revealed that the employee was full-time employee, hire date of February 7, 2024, working as a Nurse aide. Review of facility investigation revealed that Employee E15, nursing assistant certification expired on [DATE]. Interview with Employee E15, Nursing Home Administrator on [DATE] at 10:30am confirmed that Employee E15 remained fulltime in facility between [DATE] and [DATE]. 28 Pa. Code 201.19(7) Personnel records		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policy, as well as interview with staff and residents, it was determined that facility did not ensure to honor residents' preferences related to fresh air breaks and activities for two of 33 residents reviewed (Resident R58 and Resident R16). Findings include: Review of facility policy 'Activity Programs,' reviewed on April 2025, indicates that activity programs are designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident. Further review of policy indicates that activities offered are based on the comprehensive resident-centered assessment and the interest and preferences of each resident. Interview with Resident R58 on Monday, December 29, 2025, at 11:45 am, revealed that the only residents who are accommodated with fresh air breaks are the ones who smoke. Further interview with R58 revealed that she is non-smoker, and when she attempts to bring up fresh air break times during resident council meetings, the staff who hold meeting do not address her preference. Interview with facility's activities director, employee E3, on Tuesday, December 30, 2025 at 3:00 pm, revealed that facility currently does not offer fresh air breaks to non-smoking residents' due to weather conditions. Review of Resident R16's clinical record revealed resident admitted to facility on February 27, 2020 with diagnosis of TBI (Traumatic Brain Injury), Major Depressive Disorder and Schizophrenia. Review of Resident R16's BIMS (Brief Interview for Mental Status) assessment dated [DATE], resident scored 11, indicating resident is moderately impaired. Interview with Resident R16 on December 29, 2025 at 12:00pm, We just don't get fresh air unless you are smoking. I feel locked up when I can't go outside, it's terrible. I want to go outside sometimes and they just don't let us. Further interview revealed that resident has expressed this on multiple occasions and no one listens. 28 Pa Code 211.18(b)(1) Management		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of facility policy, clinical record review, and interviews with residents and staff, it was determined that the facility failed to accurately document resident council concerns as grievances, failed to record follow-up actions and resolutions in resident council minutes, and did not ensure that residents were informed of outcomes, affecting the resident council's ability to function as a formal grievance forum for 7 of 19 residents in resident council attendance. (Resident 33, R44, R70, R85, R152 and R167) Findings include: Review of facility policy titled Clinical Manual - Social Services Manual (last reviewed April 2025) revealed that resident council meetings must be held at least monthly and serve as the formal, legally mandated forum for residents to voice concerns regarding care, treatment, and living environment. The policy requires that all concerns raised during resident council meetings-whether individual or collective-be treated as grievances, followed in accordance with the facility's grievance policy, and communicated back to residents. The policy requires that resident council minutes accurately document concerns raised, actions taken, and follow-up, serving as the official written record of grievances and their resolution. Addressing concerns verbally without documentation does not meet policy requirements. Review of resident council meeting minutes for the previous three months dated September 24, 2025; October 28, 2025; and November 28, 2025, revealed that concerns were consistently documented as no concerns across multiple departments, with minimal notation of issues and no documentation of grievance follow-up or resolution. September 24, 2025: Minutes documented attendance and departmental reports indicating no concerns. Maintenance noted a toilet seat issue on E Wing was fixed or would be fixed. No grievances or documented follow-up actions were recorded. October 28, 2025: Minutes documented attendance and one housekeeping concern marked as resolved. All other departments documented no concerns. No documentation of grievance tracking, corrective actions, or communication back to residents was recorded. November 28, 2025: Minutes documented attendance with all departments indicating no concerns. No grievances or follow-up actions were recorded. Interview with seven residents (R33, R44, R70, R85, R152, R164, and R167) during the resident council meeting held on December 30, 2025, at 10:30 a.m. revealed that residents voiced multiple ongoing concerns related to food services, staffing, physical therapy, supplies, and environmental issues. Residents stated that these concerns are raised repeatedly during monthly resident council meetings and are not resolved or communicated back to residents. Interview with the Activities Director Employee E3 on December 30, 2025, at 1:40 p.m. revealed that she attends all resident council meetings and confirmed that residents voice concerns during meetings. She stated that she does not include these concerns in the resident council minutes if she addresses them verbally during the meeting or if she completes a separate grievance form and forwards it to Social Services. She confirmed that grievances raised during resident council meetings are not consistently documented in the meeting minutes. Review of the resident and family grievance log revealed grievances that were not reflected in resident council minutes: September 2025: Grievances related to nursing care, customer service, missing items, and food services were documented in the grievance log but not in the September 24, 2025 resident council minutes. October 2025: Grievances related to housekeeping, customer service, nursing care, missing items, and medication issues were documented in the grievance log but not in the October 28, 2025 resident council minutes. Interview with Resident R33 on December 30, 2025 at 10:55 a.m. confirmed that resident council minutes were inaccurate. The resident stated she takes personal notes at every meeting and that complaints and concerns are consistently raised but are not reflected in the official resident council minutes. Review of attendance records confirmed Resident R33 attended the resident council meetings. 28 Pa. Code 201.18 (e)(3) Management 28 Pa. Code 201.29 (a) Resident Rights		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on clinical record review, staff interviews, and incident/accident documentation, the facility failed to demonstrate that it conducted a thorough, timely, and documented investigation into an allegation of misappropriation of resident property, for one of 33 residents reviewed. (Resident R70) Findings include: Review of the facility's policy titled Incident Reporting and Investigation of Accident Hazards, Supervision, Assistive Devices last reviewed October 2025 revealed the facility requires that all incidents and adverse occurrences be fully, timely, and thoroughly investigated until a clear conclusion is reached. An investigation is considered incomplete if required information, documentation, analysis, or approvals are missing. Key points related to incomplete investigations include: Immediate initiation is mandatory: All incidents involving injury, abuse, neglect, mistreatment, or unknown origin must be reported immediately to the DON and Administrator, and an investigation must begin without delay. Comprehensive data collection is required: Incomplete investigations may result from missing incident reports, unsigned or unreviewed witness statements, lack of resident assessments, missing timelines, or failure to identify all parties involved. The policy requires collection of factual witness statements, environmental observations, resident assessments, and supporting documentation. Required review and oversight: Incident reports and investigations must be reviewed by supervisory staff (Unit Manager, DON, ADON, NHA). Failure to obtain required reviews, signatures, or approvals (including regional or executive approval for reportable events) renders the investigation incomplete. Analysis and conclusions must be documented: An investigation is not complete unless it includes documented conclusions addressing: How the incident occurred Why it occurred (if determinable) Whether it was preventable Root cause analysis, when possible Follow-up actions are required: Immediate corrective actions, care plan revisions, and prevention measures must be documented. Missing or unimplemented corrective actions indicate an incomplete investigation. Additional investigation when needed: If facts are insufficient, abuse is suspected, or reasonable cause cannot be established, the policy requires continued investigation, additional statements, and escalation to the DON, Administrator, and appropriate agencies. Final review and closure: Investigations must be finalized, signed, logged, and trended. Incomplete investigations may occur if documentation is not returned for final review, not forwarded for required signatures, or not included in tracking and QAPI review. Review of documentation reported to the State Survey Agency relate to Resident R70 misappropriation of resident property, revealed that the resident contacted social services on December 8, 2025 and notified the Social Service Director that on November 24, 2025, someone came into a room claiming to be a social worker and took her debit card an ID and had her sign some forms. Resident R33 reported that she received a notification on November 26, 2025 from her bank stating that they suspected fraudulent activity. Resident claims \$400 was spent out of her account. In conclusion, the bank has reimbursed the money to her account and issued her new card, an investigation was started, the police and Protective Services were contacted. Continued review of reported incident revealed Resident R70 could not identify the person that came into a room only that it was a female and wore a business suit. The Nursing Home Administrator (NHA), Employee E1 instructed staff who do not dress in scrubs to visit this resident while rounding on December 9, 2025 and December 10, 2025. The resident did not recognize any of the employees. Review of the facility's investigation included a police report, the statement of Resident R33 to Social Services, and the Social Services initial assessment of Resident R70, which indicated the resident scored 15 on the BIMS (brief interview of mental status), reflecting intact cognition. The facility concluded that the NHA, Employee E1 was unable to substantiate that the purchase on the resident's card resulted from someone taking it while at the facility, noting that the resident could not provide a description of the alleged individual or identify anyone involved. The investigation did not include interview with other potential witnesses. Interview with NHA, Employee E1, on January 5, 2025, at approximately 9:00 a.m., acknowledged that the resident reported money missing and initially alleged that an individual (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	presenting as a facility employee entered her room and took her funds. Employee E1 stated that the resident's account changed multiple times, including claims that the withdrawals occurred outside the facility, possibly related to a motel stay prior to admission, and later speculation that the individual may not have been a facility employee. NHA, Employee E1 further stated that the facility did not have further involvement because law enforcement and the bank would not release additional information without a subpoena. He believed the incident did not occur within the facility. Based on the resident's changing descriptions, he informally showed the resident several staff members who might match her description but stated the resident was unable to identify anyone. He acknowledged that the resident could not consistently describe the alleged individual and that no staff member matched the description provided. Employee E1 confirmed that while he spoke generally with staff and followed up with the resident, there was no clear documentation of a comprehensive internal investigation, including: A documented timeline of events, Review of staff schedules and sign-in logs, Interviews with other residents on the unit, Identification of potential witnesses, Documentation of investigative findings and conclusions. 28 Pa. Code 201.18(b)(3) Management		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on observation, clinical record review, and staff interview, the facility failed to ensure a comprehensive assessment was completed upon admission for one of eight residents reviewed. (Resident R 175) Findings include: Review of Resident R175's admission Minimum Data Set (MDS- assessment of resident care needs) dated December 17, 2025, revealed that the resident entered the facility on December 11, 2025, with diagnosis including orthopedic conditions, malnutrition, diabetes (failure of the body to produce insulin), and respiratory failure. Resident R175's functional abilities were assessed as independent with supervision and the use of a wheelchair and a walker. The resident's brief interview of mental status (BIMs) was 14 indicating intact cognition and the resident is noted to have severely impaired vision with no corrected lenses. Interview with resident on December 29, 2025, approximately 11:00 AM revealed resident has concerns of not being cared for (her/his) blindness stating that there's no interventions for (her/his) blindness. The resident stated that (she/he) was independent but cannot see and had difficulty and needed some assistance. The nurses leave the medications on the overside bed tray and (she/he) can't see them. Review of Resident R 175's clinical record primary diagnosis did not include any visual deficit or legal blindness. Interview with Registered Nurse Assessment Coordinator, Employee E5 confirm that Resident R175 was legally blind and confirmed that it was not coded on the diagnosis list of the MDS. 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of facility policy and interview with staff and residents, it was determined that facility failed to develop and implement a comprehensive resident centered care plan for three of 33 residents reviewed. (Residents R69, and R175) Findings include: Review of the facility policy titled Care Planning Process and Care Conference, last reviewed May 2025, revealed the facility is required to develop and implement a comprehensive, resident-centered interdisciplinary care plan based on each resident's assessed needs, diagnoses, and functional limitations. The policy requires the care plan to be initiated upon admission and updated following completion of the comprehensive assessment, with revisions made for any change in the resident's condition. The policy further requires the facility to identify and care plan for each resident's diagnoses and impairments, including visual deficits or blindness, and to develop individualized, measurable goals with specific interventions. Each identified care plan problem must include assigned responsible disciplines, target dates, and interventions designed to promote resident safety, independence, and quality of life. An interdisciplinary team must develop the comprehensive care plan within 21 days of admission, and all staff are required to provide care in accordance with the care plan. Failure to assess, develop, implement, or revise care plans to address identified diagnoses, such as visual impairment or blindness, is inconsistent with facility policy and the requirements. Review of Resident R175's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnosis including orthopedic conditions, malnutrition, diabetes (failure of the body to produce insulin), and respiratory failure. Resident R175's functional abilities were assessed as independent with supervision and the use of a wheelchair and a walker. The resident's brief interview of mental status (BIMs) was 14 indicating intact cognition and the resident is noted to have severely impaired vision with no corrected lenses. Interview with resident on December 29, 2025, approximately 11:00 AM revealed resident has concerns of not being cared for (her/his) blindness stating that there's no interventions for (her/his) blindness. The resident stated that (she/he) was independent but cannot see and had difficulty and needed some assistance. The nurses leave the medications on the overside bed tray and (she/he) can't see them. Review of Resident R175's care plan did not include a specific problem, goal, or individualized interventions addressing legal blindness. Interview with the Unit Manager Nurse, Employee E9 on January 4, 2026, confirmed the resident is legally blind and confirmed the care plan does not specifically address the resident's visual impairment or include interventions to improve safety and comfort related to blindness. Review of Resident R69's clinical record revealed medical diagnosis of cerebral infarction (stroke), hemiplegia (paralysis) affecting right nondominant side, need for assistance with personal care. Observations of Resident R69 on December 29, 2025, at 10:30 am, revealed resident laying on his right side with right arm underneath him. Interview with facility's Rehabilitation Director, Employee R4, on Friday, January 2, 2026 at 11:30 am, revealed that Resident R69 was to have pillow prop up in bed under right upper extremity. Review of occupational therapy notes, dated December 3, 2025, indicated that Clinician provided education regarding wearing R (right) sling when in therapy or out of bed for increased comfort. Review of R69's care plan revealed no evidence of interventions related to pillow and sling provision for resident's comfort. 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 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** Based on review of facility policy, review of a facility document, interviews with residents and staff and review of clinical records, revealed that the facility failed to meet the standard of care for diabetes management and hypoglycemia monitoring in a timely manner for one of 11 residents reviewed. (Resident R164) Findings include: Review of facility policy titled Hypoglycemia Diabetic Management last reviewed May 2025 revealed the facility requires staff to quickly and safely respond to residents exhibiting signs or symptoms of hypoglycemia, to manage diabetes to prevent hypoglycemia, to monitor blood glucose per physician orders, and to ensure timely assessment, intervention, physician notification, and documentation of hypoglycemic episodes. Review of facilities policy titled Care Planning Process and Care Conference last revised March 19 2025 revealed the facility's policy requires the development and implementation of a comprehensive, resident-centered interdisciplinary plan of care for each resident, based on completed assessments and in compliance with federal and state regulations. A baseline care plan must be initiated upon admission and completed within 48 hours, addressing the residents' primary diagnosis, identified risks, and individual needs. The care plan serves as a working document that guides staff in delivering care consistently with professional standards. The interdisciplinary team (IDT)-including nursing, physician (as applicable), dietitian, social services, rehabilitation, nursing assistants, and the resident and/or resident representatives are responsible for care plan development, review, and revision. Care plans must include specific, measurable goals, interventions, responsible disciplines, and target dates, and must be updated with any change in condition. According to the American Diabetes Association (ADA) and the Centers for Disease Control and Prevention (CDC), hypoglycemia is generally defined as blood glucose level below 70 Mg dl. When blood sugar drops too low, individuals may experience symptoms as shakiness, sweating irritability, confusion, dizziness or lightheadedness, rapid heartbeat and blurred vision. If untreated hypoglycemia may progress to severe symptoms, including loss of consciousness, seizure, or coma which can be life-threatening. Initial treatment typically involves the immediate intake of fast acting carbohydrates, such as glucose tablets, juice or non diet sodas, followed by reassessment of blood glucose levels. In severe hypoglycemia, the ADA defines the condition as a medical emergency, particularly when the blood glucose levels fall below 54 MG Slash DL in these situations assistance from another person is required which may include administration of glucagon or activation of emergency medical services. While mild hypoglycemia may be managed by the individual with fast acting carbohydrates severe hypoglycemia requires urgent medical interventions both the ADA and the CDC stressed the importance of timely monitoring, reassessment, and individual lies care planning after hypoglycemic episodes to prevent reoccurrence and avoid serious harm. Review of the American Diabetes Association (ADA) standards of care 2025, section 14: Diabetes Care in Long-Term Care Settings, Diabetes care 2025;48(Suppl 1): S1-S3 state that episodes of hypoglycemia require prompt evaluation and individualized intervention and that the recurrent or severe hypoglycemia should trigger reassessment of the diabetes management plan to prevent further events. The ADA emphasizes that blood glucose monitoring, individualized treatment adjustments, dietary review, and ongoing risk assessments are integral parts of safe diabetes care. Review of The Centers for Disease Control and Prevention CDC Hypoglycemic Guidance-Immediate treatment and post episode monitoring to prevent recurrence. https://www.cdc.gov/diabetes/treatment/treatment-low-blood-sugar-hypoglycemia.html recommends immediate treatment of hypoglycemia blood glucose less than 70MG per DL and frequent post episode monitoring and care plan review to identify contributing factors and reduce reoccurrence. Review of Resident R164's hospital discharge orders dated December 3, 2025, revealed that Resident R164's medication list with instructions to continue the following medications: one touch delica plus Lancet 33GAGE miscellaneous for type two diabetes mellitus with chronic kidney (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Chestnut Hill Lodge Health and Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disease on chronic dialysis, unspecified whether long-term insulin use. With instructions one Lancet 4 times a day for diabetes management, which was not transferred to resident physician orders, indicating the hospital discharge recommendations for Accu-checks were not implemented upon admission. Review of Resident R164's admission Minimum Data Set (MDS -a federal mandated assessment tool for all residents) dated December 9, 2025, revealed that Resident R164 entered the facility on December 3, 2025 with diagnosis including Hypertension (is a condition where blood pressure is consistently elevated above normal levels), renal failure (a condition in which the kidneys lose the ability to filter waste and excess fluids from the blood effectively , diabetes mellitus (is a chronic condition where the body either becomes resistant to insulin or doesn't produce enough insulin leading tear elevated blood sugar levels), seizure disorder(also known as epilepsy is a neurological condition characterized by recurrent unprovoked seizures), and anxiety(is a mental health condition characterized by excessive worry fear or nervousness often interfering with say the activities). The residents' medications include an antidepressant, anticoagulant, antibiotic, diuretic, and the anti-convulsant. Resident R164 receives dialysis. Further review of resident R 164 MDS revealed residents cognition assessed with a brief interview of mental status (BIMs) score of 14 indicating that the resident cognition is intact. Review of resident R164's care plan revealed this resident is at risk for complications from hemodialysis related to end stage renal disease-initiated December 4, 2025, with interventions to adjust medication schedule necessary on dialysis days, maintain enhanced barrier precautions, monitor permcath for signs of bleeding swelling or infection every shift in is needed monitor vital signs as ordered. Continued review of resident's care plan revealed a focus of nutrition, the resident at is at risk for alteration in nutrition hydration related to facility adjustment diabetes and stage renal disease and depression date December 4, 2025 with interventions of diet is ordered, encourage food and fluid, monitor for signs or symptoms of hyper or hypoglycemia, monitor PO (by mouth) intake, supplements as ordered. The goal was for Resident R164 will have no signs and symptoms of hyper or hypoglycemia through the next review date-December 4, 2025. Resident R 164 does not care planed for diabetes management, or hypoglycemia. Review of the Registered Dietitian's nutrition assessment dated [DATE], revealed that the resident was ordered a renal carbohydrate-controlled diet and had a good appetite, consuming approximately 75% of meals. However, there was no evidence of diabetic snack orders or coordinated dietary interventions related to blood glucose management, and no reassessment of nutritional needs following hypoglycemic episodes. R Review of Resident R164's nursing notes revealed that the resident experienced multiple documented hypoglycemic episodes: -December 17, 2025, the resident experienced a hypoglycemic with a documented blood sugar of 48 mg/dl episode requiring glucagon administration. -December 19, 2025, the resident's blood glucose was documented at 34 mg/dL following dialysis. -December 29, 2025, the resident experienced another hypoglycemic episode with a documented blood glucose of 44 mg/dL, which was associated with a fall. Continued review of resident's clinical records revealed there was no evidence of timely physician reassessment, modification of the diabetes management plan, or consistent escalation of monitoring until December 30, 2025, when hypoglycemia protocols, endocrinology consultation, and routine snack orders were initiated. Review of the resident's December 2025 Medication Administration Record (MAR) revealed inconsistent and incomplete documentation of blood glucose monitoring. Continue review of December 2025 MAR revealed that blood sugar checks were in place for specified periods. Nursing staff documented that blood sugars were checked without recording actual glucose values, and multiple required blood glucose readings were not recorded. An interview with Resident R1 conducted on December 29, 2025, revealed that the resident identified herself as a diabetic and reported that she was not receiving any snacks. The resident stated that her blood sugar levels continued to drop and that, despite these episodes, she was still not being provided snacks to help manage her blood glucose. A second interview with the resident conducted December 30, 2025, at 11:00 a.m. revealed continued concerns regarding lack of diabetes management. The resident stated that no one was (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	taking care of her blood sugar monitoring and reported that she had passed out the night before due to low blood sugar. The resident further stated that she was still not receiving snacks at that time. Interview conducted on January 2, 2026, at 10:35 a.m., the resident stated that she had still not been offered any snacks. She reported experiencing multiple episodes of loss of consciousness and stated that she had fallen three times, recalling only waking up with staff around her. The resident stated she did not believe she was injured but described feeling scared and uncertain following the incidents. The resident further reported that she had not seen a physician and had not had any discussion regarding her diabetes or blood sugar management. Interview conducted on January 2, 2026, with the Medical Director, Employee E7, acknowledged that the resident experienced three documented hypoglycemic episodes and stated that while an isolated episode may not require increased monitoring, recurrent hypoglycemia warrants further evaluation and escalation of care. Employee R7 confirmed that consultation with endocrinology following repeated events was medically appropriate. Employee E7 further stated that dialysis patients are at increased risk for glucose variability and require careful coordination of monitoring, nutrition, and dialysis schedules. Phone interviews with the attending physician, Employee E8 on January 2, 2025, revealed acknowledgment of the resident's hypoglycemic episodes and confirmation that increased monitoring was ordered following recurrent events. The physician explained that hypoglycemia in dialysis patients is often related to nutritional intake and dialysis timing rather than medication use and emphasized the importance of dietary interventions and meal coordination. The physician acknowledged documentation gaps and indicated that additional documentation would be completed. Interviews with Licensed nurse manager, Employee E9 revealed delays in initiating blood glucose monitoring, and missed meals related to dialysis scheduling. The nurse manager acknowledged inconsistencies in pre- and post-dialysis documentation, gaps in communication, and failure to consistently ensure that diabetic residents received meals or snacks when leaving the facility for dialysis. These failures contributed to recurrent hypoglycemic episodes and delayed interventions. Continued interview revealed that typically when a resident enters the facility with a diagnosis of diabetes the physician orders include a batch order including accu checks (blood sugar monitoring). 28 Pa Code 201.18(b)(1) Management 28 Pa. Code 211.2(d)(3) Medical Director 28 Pa. Code 211.10 (b)(c) Care Policies 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on review of facility provided documentation, review of clinical records and interview with staff, it was determined facility did not ensure to complete medication regimen reviews according to professional standards of practice for two of five residents reviewed (Residents R3, and R8) Findings include: Review of facility policy 'Medication Regimen Review,' reviewed in May 2025, indicates that the attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical. Review of facility provided 'Consultant Pharmacist's Medication Regimen Review,' for recommendations created between August 1, 2025, and August 6, 2025, revealed that dose reduction was recommended for Resident R3 related to Abilify prescription. Further review of 'Consultant Pharmacist's Medication Regimen Review,' revealed no evidence of physician rationale for Resident R3. Review of Consultant Pharmacist's Medication Review Regimen, for recommendations created between July 1, 2025, and July 16, 2025, revealed recommendation for Resident R8, stating Federal Guidelines necessitate review and possible attempts at psychoactive dose reduction. Please review this resident's Lexapro order considering if the resident is a candidate for decrease in dose. Possible responses to circle: 1. After review and assessment the benefit to the resident outweighs any observed risk. No reduction at this time. 2. The resident's condition warrants the following dosage reduction (see order below). 3. The resident's current condition warrants further increase or change in therapy (see order below). Further review of this Consultant Pharmacist's Medication Review Regimen revealed Physician/ Prescriber disagreed with recommendation, however provided no rationale. Review of Consultant Pharmacist's Medication Review Regimen, for recommendations created between August 1, 2025, and August 6, 2025, revealed recommendation for Resident R8, stating Federal Guidelines necessitate review and possible attempts at psychoactive dose reduction. Please review this resident's Risperdal order considering if the resident is a candidate for decrease in dose. Possible responses to circle: 1. After review and assessment the benefit to the resident outweighs any observed risk. No reduction at this time. 2. The resident's condition warrants the following dosage reduction (see order below). 3. The resident's current condition warrants further increase or change in therapy (see order below). Further review of this Consultant Pharmacist's Medication Review Regimen revealed Physician/ Prescriber disagreed with recommendation, however provided no rationale. Interview with Employee E7, Medical Director confirmed findings. 28 Pa Code 211.9(k) Pharmacy services 28 Pa Code 211.12(d)(3) nursing services		

Department of Health & Human Services
Centers for Medicare & Medicaid 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. Based on observation, review of facility policy and procedures and interviews with residents and staff, it was determined that the facility failed to maintain an effective infection control program related to water cup distribution for three of 33 residents observed. (Resident R8, Resident R121 and Resident R18) Findings include: Review of Water Pitcher Pass/ cleaning review date April 2025, revealed that Styrofoam cups will be replaced nightly on 11-7 shift. Cups should be labeled with date of placement. Continued review revealed Nursing staff will fill water pitchers/Styrofoam cups with ice and fresh water placing them at bedside. Interview with Resident R8 on December 29, 2025, at 10:30am, revealed resident doesn't feel like she gets offered enough water and they always use the same cup and fill it at the bathroom sink. Observation of Resident R8's Styrofoam water cup on bedside table on December 29, 2025, at 10:30am, revealed that cup was labeled with a date of December 18, 2025, 11p-7a. Interview with Resident R121 on December 29, 2025, at 10:30am, revealed that cups get filled in the bathroom sink when requesting water and cups do not get replaced often. Observation of Resident R121's Styrofoam water cup on bedside table on December 29, 2025, at 10:35am, revealed that cup was labeled with a date of December 26, 2025, 11p-7a. Interview with Employee E12, Nursing Assistant on December 29, 2025, at 10:45am, confirmed findings and stated, I don't know what happened, I am agency, but I think cups are supposed to be changed every night shift. Interview with Resident R18 on December 29, 2025, at 10:55am, revealed concerns related to water cups filled in bathroom sink of shared resident bathroom and that resident was disgusted by this. 28 Pa Code 211.12 (d)(1)(5) Nursing services		