STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395449	A. Building B. Wing	11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapel Manor	1104 Welsh Road Philadelphia, PA 19115

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and staff interview, the facility failed to ensure Resident R1 who required 1:1 supervision received adequate supervision to prevent accidents, which resulted in actual harm to Resident R1 who sustained an unwitnessed fall from bed and sustained a traumatic brain injury for one of five residents reviewed (Resident R1).This deficiency was cited identified as past non-compliance.Findings Include:Review of the facility policy titled Enhanced Patient Supervision: Continuous 1:1, revised September 15, 2025, revealed, When using Continuous 1:1 Supervision, designated staff will be assigned to manage the 1:1 supervision of the patient. The designated staff will only be involved with the delivery of care to this patient and no other patient (where possible, a staff member already known to the patient is recommended to ensure consistency of care). The designated staff must be with the patient at all times, must obtain coverage for breaks, and will provide positive interaction in conjunction with therapeutic interventions. Continuous 1:1 Supervision will be provided per nursing judgment or when recommended by a physician/advanced practice provider (APP). Allocation of staff:The nurse in charge of each shift has the responsibility to allocate staff(s) to carry out Continuous 1:1 Supervision.The staff allocated to supervise the patient will not discontinue the supervision until the next staff confirms they have taken responsibility for supervising the patient. Additional staff may be required when supervising very high-risk patients. Review of the clinical record for Resident R1 revealed the resident was readmitted to the facility on [DATE], with diagnoses including restlessness and agitation, lack of coordination, and difficulty in walking. Review of the entry/discharge MDS (Minimum Data Set - assessment of resident care needs) for Resident R1 dated October 2, 2025, revealed the resident's cognitive skills for daily decision making were severely impaired. The MDS indicated the resident was dependent on staff for transfers and toileting. There was no assessment of resident ambulation documented in the MDS assessment. Review of physician note for Resident R1 dated October 11, 2025, revealed the resident, a long-term care resident, was hospitalized from [DATE], through October 10, 2025, after sustaining a fall on September 29, 2025, at the facility. Additional review revealed, an initial evaluation at another hospital included imaging confirming a displaced left femoral neck fracture. The resident sustained a closed displaced fracture of the left femoral neck and underwent left hip replacement. Recommendations included full supervision and assistance with mobility. Review of physician progress note for Resident R1 dated October 13, 2025, at 9:56 a.m., revealed the resident was on 1:1 supervision and to continue 1:1 supervision. Review of nursing note for Resident R1 dated October 13, 2025, revealed the resident was noted with safety concerns and provided 1:1 supervision. Review of physician note for Resident R1 dated October 14, 2025, at 8:08 a.m., revealed during the weekend, staff reported continuous agitation and restlessness, with repeated attempts to get out of bed, requiring 1:1 supervision. Review of physician note for Resident R1 dated October 16, 2025, at 10:30 a.m., revealed a recommendation for fall precautions and 1:1 supervision. Review of the facility incident investigation dated October 17, 2025, revealed Resident R1 who was dependent for transfers and all Activities of Daily Living, at approximately 4:35 a.m., while Nurse aide, Employee E3 was performing care to another resident, she heard a noise and immediately went to Resident R1's room where resident was observed on the floor. The resident was last seen by Nurse aide, Employee E3 at 4:25 a.m., in bed, in a low position, with the call light within reach. Nurse aide, Employee E3 immediately called for the nurse, and upon assessment, Resident R1 was found with lacerations to the left eyebrow, forehead, and an abrasion on the left lower arm. Resident R1 was unable to recall the incident or report any pain. Further review of the facility's incident report revealed that the Nursing Supervisor and physician were notified and determined that the resident should be sent to the hospital for evaluation due to the head injury. The resident was transferred to the hospital for further evaluation via ambulance. Upon investigation, it was noted that the resident was placed on 1:1 increased behaviors on October 16, 2025. Follow-up call made to the hospital notified that results of CT (computed tomography scan- medical image that uses a combination of x-ray and computer image to create crossed sectional images of the inside of the body) were positive for subdural hematomas. Investigation was immediately initiated. Nurse aide, Employee E3 was suspended pending investigation. Investigation concluded and found that Nurse aide, Employee E3 did leave Resident R1 unattended while providing care for another resident when the fall occurred. Review of a written statement from Nurse aide, Employee E3 dated October 17, 2025, at 4:35 a.m., revealed that she was assigned to do 1:1 supervision with Resident R1 and left the room without notifying anyone to clean

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility failed to provide adequate staffing to ensure continuous supervision for Resident R1, who required 1:1 observation as ordered by the physician. This failure resulted in actual harm to Resident R1 who was left unsupervised, sustained a fall from the bed, requiring transfer to the hospital and diagnosis of traumatic head injury for one of five residents reviewed. (Resident R1) Findings Include: Review of facility assessment revealed under section titled, Function - Care Requirements 3. Staff/Personnel required: Consider the specific needs of each resident unit in the facility to adjust as necessary (i.e. number of staff, skill sets). This includes the staffing needs for each shift, such as day, evening, night, weekends, and adjust as necessary based on any significant changes to the resident population for person centered care planning. Cognitive care Requirements 3. Staff/Personnel required: Consider the specific needs of each resident unit in the facility to adjust as necessary (i.e. number of staff, skill sets). This includes the staffing needs for each shift, such as day, evening, night, weekends, and adjust as necessary based on any significant changes to the resident population for person centered care planning. Review of the clinical record for Resident R1 revealed the resident was readmitted to the facility on [DATE], with diagnoses including restlessness and agitation, lack of coordination, and difficulty in walking.Review of the Entry/Discharge MDS (Minimum Data Set - assessment of resident care needs) for Resident R1 dated October 2, 2025, revealed the resident's cognitive skills for daily decision making were severely impaired. The MDS assessment indicated the resident was dependent on staff for transfers and toileting. There was no assessment of resident ambulation documented in the MDS.Review of the facility's incident investigation, dated October 17, 2025, revealed Resident R1, dependent on transfers and all ADLs, at approximately 4:35 a.m., while Nurse Aide, Employee E3 was performing care to another resident, she heard a noise and immediately went to Resident R1's room where the resident was observed on the floor. The resident was last seen by Nurse aide, Employee E3 at 4:25 a.m., in bed, in a low position, with the call light within reach. Nurse aide, Employee E3 immediately called for the nurse, and upon assessment, Resident R1 was found with lacerations to the left eyebrow, forehead, and an abrasion on the left lower arm. Resident R1 was unable to recall the incident or report any pain. Further review of the facility's investigation revealed that the Nursing Supervisor and physician were notified and determined the resident should be sent to the hospital for evaluation due to head injury. The resident was transferred to the hospital for further evaluation via ambulance. Upon investigation, it was noted the resident was placed on 1:1 supervision due to increased behaviors on October 16, 2025. Follow-up call made to the hospital revealed the results of CT scan were positive for subdural hematomas. Investigation was immediately initiated. Employee E3 was suspended pending investigation. Investigation concluded and found that Employee E3 left Resident R1 unattended (without supervision) while providing care for another resident when the fall occurred.Review of a written statement from Nurse aide, Employee E3 dated October 17, 2025, at 4:35 a.m., revealed she was assigned to do 1:1 supervision with Resident R1 and left the room without notifying anyone to attend to other resident's personal hygiene needs. Nurse aide, Employee E3 indicated the resident was restless throughout the night. Employee further indicated the resident did not have non-skid footwear on because the resident removed them. Employee E3 stated she was not able to see Resident R1 from the room where she was providing care.Review of the hospital records dated October 17, 2025, confirmed the resident was admitted with diagnoses of Traumatic Brain Injury, Subarachnoid Hemorrhage (bleeding in the area between the brain and the thin tissues that cover and protect it) and cerebral contusion from the fall.Review of CT (Computed Tomography scan) of the head for Resident R1 dated October 17, 2025, revealed the scan results showed trace acute subarachnoid hemorrhage.Review of nursing note for Resident R1 dated October 17, 2025, revealed that at 4:35 a.m., the nurse was notified Resident R1 was on the floor. Upon arrival to resident's room, Resident R1 was observed at the bottom of the bed in a sitting position with a laceration to the left eyebrow area and the left side of the forehead. A skin abrasion on the left elbow was also seen. A neurological assessment was performed and noted to be normal within the resident's baseline. The physician was notified and ordered for the resident to be transfer to the hospital.Further review of the progress note revealed the resident was admitted with Traumatic Brain Injury.Review of nursing note for Resident R1 dated October 13, 2025, revealed that the resident was noted with safety concerns and provided 1:1 supervision.Review of physician progress note for Resident R1 dated October 13, 2025, at 9:56