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	06/02/2026

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 0600 Level of Harm - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility policies and facility documentation and interviews with residents and staff, it was determined that the facility failed to ensure that two of five residents reviewed were free from abuse.(Resident R1 and Resident R2). Findings include: Review of a facility policy titled, Abuse Prohibition revised November 14, 2025, revealed that the policy is that Centers prohibit abuse, mistreatment, neglect, misappropriation of resident/patient (hereinafter patient) property, and exploitation for all patients. And the purpose is, to ensure that Center staff are doing all that is within their control to prevent occurrences of abuse, mistreatment, neglect, exploitation, involuntary seclusion, injuries of unknown source, and misappropriation of property for all patients. Review of the clinical record for Resident R3 revealed that the resident had been admitted to the facility on [DATE], with diagnoses including bipolar disorder (also known as manic depressive illness or manic depression, is a mental health condition characterized by significant mood swings, including manic (or hypomanic) episodes and depressive episodes). Further review revealed a care plan for resident being resistive to care such as medications, tube feed infusion, pulls at PEG tube and foley catheter related to intellectual disability, anxiety, schizophrenia (mental disease characterized by loss of reality contact), depression (major loss of interest in pleasurable activities), bipolar and difficulty adjusting to recent changes in condition.Continued review of Resident R3's clinical record indicate that Resident R3 was discharged back to her group home on May 20, 2026. Review of documentation submitted to the State Survey Agency revealed that Resident R3 reported on April 21, 2026, that the night before the nurse aide (Employee E19) slapped her on the face while providing her care. The report also states that Employee E19, the nurse aide giving care to Resident R3 the night of April 20, 2026, was suspended pending the outcome of the investigation. The facility investigation determined that the allegation of abuse was substantiated based on interviews with Resident R3 and her roommate (Resident R11) who witnessed and confirmed the allegations. Interview with Resident R11 at 1:15 p.m. on June 2, 2026, confirmed that she witnessed the altercation between her roommate (Resident R3) and the nurse aide who gave them care (Employee E19) on the evening of April 20, 2026. She said she remembered it and that she felt the facility had handled the situation appropriately. Review of the witness statement of Employee E20, the nurse aide that was passing breakfast trays on A Wing on April 21, 2026, when Resident R3 told her that the nurse aide giving her care the night before had hit her. She further stated that when she went to give care to her roommate, Resident R11, she also said that the nurse aide, Employee E19, had hit Resident R3. She further stated that she reported this to the night supervisor, Employee E21. Review of the telephone interview statement from on Employee E19, the nurse aide who allegedly struck Resident R3, revealed that while attempting to provide care to Resident R3, she kicked her in the chest and struck her in the face knocking her glasses off. She states she immediately stopped care and reported it to the charge nurse, Employee E22. She said she waited a little while and returned to finish Resident R2's care. Review of telephone interview of nurse aide Employee E19 on April 24, 2026, in the presence of nurse aide and union representative, Employee E23, revealed the following. While giving (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care to Resident R3 on the evening of April 20. 2026, she kicked me and my glasses fell off my face. I stepped back and asked her why she did that, and then I finished her care and left the room. I went and told the nurse, Employee E22 that Resident R3 was acting out and I did not return to the room after that. Review of an interview with Employee E22, the charge nurse, confirmed that Employee E22 was assigned to Resident R3 on the evening shift on April 20, 2026. Employee E22 also confirmed that she administered medications to the resident and was not told about any incident between Resident R3 and a staff member, Employee E19? Review of telephone interviews with three nurse aides and one licensed nurse also working on A Wing on April 20, 2026, all answers no have been aware of an incident between Resident R3 and Employee E19. Interview with Employee E1, Assistant Nursing Home Administrator (ANHA), and the Administrator on June 2, 2026, at 2:05 p.m. confirmed that the investigation was into abuse by Employee E19 on April 20, 2026, toward Resident R3 was substantiated based on the statements of Resident R3, and her roommate Resident R11. They indicated that Employee E19 was terminated after the investigation was substantiated. Review of the clinical record for Resident R2 revealed that the resident had been admitted to the facility on [DATE], with diagnoses including end stage renal disease (the final stage of chronic kidney disease, where the kidneys can no longer function adequately to sustain life without dialysis or a kidney transplant). Review of documentation reported to the State Survey Agency on May 20, 2026, by nursing staff that a transportation driver entered Resident R2's room for a scheduled dialysis transport then exited the room alleging that Resident R2 struck him. The nurse, Employee E11, immediately went to assess the situation at which time the driver reentered the room and became verbally aggressive with Resident R2 and started throwing food items from the meal tray onto the floor. Staff reported that the driver pointed the tray toward the resident and allegedly struck Resident R2's left arm twice. Staff immediately intervened and escorted the driver out of the building. Review of the Employee E11's May 20, 2026, nurse note in the medical record revealed the same narrative as above, and that the resident was assessed for injuries and that the facility arranged alternate transportation with another company and the resident was taken to dialysis. A review of the social service note by Employee E28 dated May 20, 2026, revealed that Resident R2 was interviewed and was okay but was confused and could not give any details about the incident or if anyone hit him, and said he just was waiting for his brother to pick him up. Review of statement by Resident R2 given on May 20, 2026, in the presence of a police officer stated that his son came and hit him on his arm. Review of a May 20, 2026, statement by Resident R2's roommate, Resident R12 revealed he could not see anything during the incident as he was laying down. However he reported hearing yelling and cursing by the transport driver, and the food tray hit the floor. A review of the May 22, 2026, email from the transportation company revealed the name of the EMT (Emergency Medical Technician) driver, who was involved in the incident, confirmed receiving elder abuse training and that in the past 30 days he had only been scheduled to transport Resident R2 on May 13, 2026, and May 20, 2026. Interview with Employee E1, Assistant Nursing Home Administrator (ANHA), and the Administrator on June 2, 2026, at 2:05 p.m. confirmed that the investigation into alleged abuse by the transportation driver was substantiated. The administrator confirmed that the transportation driver had been terminated by the transport company. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 201.29(c) Resident rights 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(c) Nursing services