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	12/03/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and staff interviews, it was determined that the facility failed to ensure that a resident was treated with respected during a group meeting for one of four residents reviewed (Resident 35). Findings include:On September 16, 2025, at 1:30 p.m., a resident council meeting was held with seven alert and oriented residents (R93, R78, R129, R35, R149, R52, and R13). At 1:57 p.m., during the meeting, Licensed Nurse Employee E8 entered and stated, Excuse me, I need to give Resident R35 medication. Employee E8 then proceeded to administer three pills in a medication cup along with a cup of water. The nurse left the room immediately after. Resident R35, appeared uncomfortable and unprepared to take his medication in front of peers.At 2:06 p.m., following the meeting, Resident R35 was interviewed privately regarding the incident. Resident R35 reported: It made me feel uncomfortable. I was surprised when the nurse came in to give me meds-it caught me off guard.At 2:30 p.m., a meeting was conducted with the Administrator, Employee E1 and Director of Nursing, Employee E2. Both confirmed that it was not appropriate for the nurse to administer medication during the resident council meeting. 28 Pa Code 211.12(d)(1) 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

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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 review of facility policy, review of facility documentation, review of clinical records, and staff interviews it was determined that the facility failed to conduct a complete and thorough investigation related to a resident fall for one of four residents reviewed (Resident R174). Findings Include: Review of facility policy Abuse Prohibition revised October 24, 2022, revealed the facility will implement an abuse prohibition program which would include investigation of incidents and accidents. Review of Resident R174's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated April 1, 2025, revealed the resident had a Brief Interview for Mental Status (BIMS -a structured interview to assess cognitive function and orientation) score of 14 (intact cognitive response). Further review of Resident R174's the MDS revealed the resident had diagnoses of muscle weakness, osteoarthritis (joint pain and stiffness), mild cognitive impairment, and polyneuropathy (condition characterized by damage to multiple peripheral nerves, leading to symptoms such as pain, weakness, and sensory loss). Review of Resident R174's comprehensive care plan revised December 30, 2024, revealed the resident was at risk for falls related to impaired mobility. Further review of Resident R174's comprehensive care plan revised December 30, 2024, revealed the resident required assistance for transferring from one position to another related to difficulty ambulating and unsteady gait. Review of facility documentation submitted to the State Survey Agency on May 29, 2025, revealed on May 28, 205, Resident R174 had a fall on the facility van while out on an appointment escorted by facility van driver, Employee E6. Review of facility documentation revealed a statement was obtained by van driver, Employee E6. Review of the statement by van driver, Employee E6, dated May 2025, revealed Resident R174 was lifted onto the ramp [in his wheelchair] to the bus and as van driver, Employee E6, walked around to the passenger door Resident R174 pulled the wheelchair breaks and he/she fell backward, hitting his/her head on the side of the bus. Continued review of facility documentation/investigation revealed no documented evidence that a statement was obtained by Resident R174 regarding details of the incident and subsequent fall. 28 Pa Code 201.14 (a) Responsibility of licensee.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review, and staff interview, it was determined that the facility failed to ensure that the residents and/or their representative received written notice notifying them of the transfer and the reason for the move in writing and in the language and manner they understand for two residents reviewed for hospitalizations (Resident R171 and R3). Findings include:Review of Resident R171's medical records revealed that on July 21, 2025, the resident was admitted to the hospital for tachycardia (irregular heartbeat). Continued review failed to reveal documentation of a written notification to the residents or resident's representative notifying them of the transfer and the reasons for the move in writing. Interview with the facility administrator on September 18, 2025, at 12:35 p.m. confirmed this finding. Review of Resident R3's clinical record revealed that Resident R3 was transferred to the hospital on February 17, 2025, for influenza. Continued review revealed that the resident was transferred to the hospital on April 18, 2025, for lower extremity weakness. Further review failed to reveal documentation of a written notification to the residents or resident's representative notifying them of the transfer and the reasons for the move in writing. Follow-up interview with the facility administrator on September 18, 2025, at 10:29 a.m. confirmed the above-mentioned findings and stated that it is not facility practice providing the residents and/or their representative with a written notice for transfers. Further interview confirmed that the ombudsman was not notified regarding Resident R3's transfers on February 17, 2025, and April 18, 2025. 28 Pa. Code 201.14(a) Responsibility of license 28 Pa. Code 201.29(a) Resident rights

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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 facility policy, review of clinical records, observations, and staff and resident interviews it was determined that the facility failed to develop comprehensive care plan for three of 33 residents reviewed (Resident R26, R102, and R61).Findings Include:Review of facility policy Person-Centered Care Plan revised September 15, 2025, revealed the facility will develop and implement person-centered care plan for each resident with measurable objectives to meet a resident's medical, nursing, mental, and psychosocial needs. The care plan must be customized to each individual patient's preferences and needs.Review of Resident R26's comprehensive Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated August 2, 2025, revealed a Brief Interview for Mental Status (BIMS - a structured interview to assess cognitive function and orientation) was not assessed because the resident is rarely/never understood. A staff assessment of mental status was conducted which revealed Resident R26 had short and long-term memory problems.Continued Review of Resident R26's MDS dated [DATE], revealed the resident had diagnoses of hemiplegia (paralysis) or hemiparesis (weakness), aphasia (loss of ability to understand or express speech, caused by brain damage), and anxiety (characterized by feelings of tension, worried thoughts, and physical changes). Per a review of the MDS Resident R26 was dependent on staff for all activities of daily living (eating, transferring, hygiene, grooming, dressing). Review of Resident R26's comprehensive care plan revised February 8, 2022, revealed the resident had impaired communication as evidenced by difficulty making self-understood.Further review of Resident R26's comprehensive care plan revised March 5, 2024, revealed the Resident R26 had impaired cognitive function or impaired thought processes.Review of Resident R102's quarterly MDS dated [DATE], revealed the resident had a BIMS score of 15 (intact cognitive response) and diagnoses of depression (persistent feeling of sadness and loss of interest) and bipolar disorder (extreme mood swings).Review of Resident R102's comprehensive care plan revised February 27, 2025, revealed the resident was able to safely transfer in and out of bed without assistance. Continued review of Resident R102's comprehensive care plan revised November 1, 2021, revealed the resident had the tendency to exhibit sexually inappropriate behavior with other residents.Observations on September 15, 2025, at 1:25 p.m. revealed Resident R26 and R102 were sitting close together in front of the nurses' station holding hands. Interview with Resident R26 revealed the two have been in a relationship for three years. Interview on September 15, 2025, at 1:40 p.m. with Registered Nurse, Employee E7, confirmed Resident R26 and R102 enjoy sitting together and holding hands. Registered Nurse, Employee E7, indicated that Resident R26 and R102 do not spend unsupervised time alone in either room. Resident R26 and R102 reportedly sit where staff can see them and the two only just hold hands. Review of Resident R26's clinical record revealed a care plan meeting note dated August 14, 2024, that indicated a discussion was had with Resident R26's guardian regarding friendship with Resident R102 and that the guardian was informed of the resident's holding hands. The guardian agreed with the friendship and appreciated education. Review of Resident R26 and R102's comprehensive care plans revealed no documented evidence that a person-centered care plan was developed for either resident regarding the consent/boundaries of the friendship. 28 Pa. Code 211.10 (d) Resident care policies.28 Pa. Code 211.12 (d)(5) Nursing services.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on clinical records review and staff interviews, it was determined that the facility failed to follow physician orders to place hearing aids in the residents ears each morning and remove them at bedtime for one of one resident reviewed for vision and hearing (Resident R7). Findings include:Review of physician orders dated September 7, 2025, revealed staff must place hearing aids in bilateral ears in the morning and remove at bedtime. Observations conducted on September 15, 2025, at 12:30 p.m., during screening, Resident R7 could not hear the surveyor and was observed without hearing aids. Observations on September 16, 2025, at 9:44 a.m. and 1:00 p.m., revealed resident R7 did not have the hearing aids in place. Observations on September 17, 2025, at 9:30 a.m. revealed the resident hearing aids on. Follow-up observations on September 17, 2025, at 2:20 p.m. again revealed the resident without hearing aids. Interview and observations conducted on September 17, 2025, at 2:30 p.m. with Nurse Manager, Employee E10, confirmed that Resident R7 did not have hearing aids in place. Review of medication cart did not reveal the hearing aids. Continued interview revealed that the hearing aids had been misplaced and not offered to Resident R7. The hearing aids were later located in the narcotic box. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing Services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on review of facility documentation, review of clinical records, observations, and staff interviews it was determined that the facility failed to provide appropriate assistance/supervision for one of four residents reviewed for falls (Resident R174).Findings Include:Review of van driver, Employee E6, personnel file revealed the employee was hired as the facility van driver effective November 4, 2024. Review of van driver, Employee E6, job description for Positions that Involve Transporting Customers/Clients revealed the employee is responsible for assisting residents when boarding and disembarking the vehicle. The employee will operate the vehicle in a safe manner when transporting residents.Review of van driver, Employee E6, personnel file revealed a Vehicle Safety Competency dated November 15, 2024.Review of facility documentation Vehicle Safety Competency revised November 2018 revealed a competency checklist/instruction for operation of wheelchair van lift. Per the Vehicle Safety Competency the van should be placed in park with emergency brake on and wheelchair secured properly on lift platform. When loading/unloading patient on lift for a side-loading van, the patient must face away from van while on lift.Review of Resident R174's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated April 1, 2025, revealed the resident had a Brief Interview for Mental Status (BIMS -a structured interview to assess cognitive function and orientation) score of 14 (intact cognitive response).Further review of Resident R174's the MDS revealed the resident had diagnoses of muscle weakness, osteoarthritis (joint pain and stiffness), mild cognitive impairment, and polyneuropathy (condition characterized by damage to multiple peripheral nerves, leading to symptoms such as pain, weakness, and sensory loss).Review of Resident R174's comprehensive care plan revised December 30, 2024, revealed the resident was at risk for falls related to impaired mobility.Further review of Resident R174's comprehensive care plan revised December 30, 2024, revealed the resident required assistance for transferring from one position to another related to difficulty ambulating and unsteady gait.Review of facility documentation submitted to the State Survey Agency on May 29, 2025, revealed on May 28, 205, Resident R174 had a fall on the facility van while out on an appointment escorted by facility van driver, Employee E6.Review of facility incident report revealed on May 28, 2025, it was reported to nursing that Resident R174 fell while in his/her wheelchair on facility transport van. Resident R174 was being picked up from his/her appointment by the driver [Employee E6]. Van driver, Employee E6, was entering the van through the passenger double doors to get [Resident R174] into the van from the lift. Van driver, Employee E6, did not reach Resident R174 when he/she released bilateral brakes from his/her wheelchair. The van was reportedly parked on tilted/uneven ground at the time. When Resident R174 released the brakes, the wheelchair rolled backward due to the tilt of the ground and the wheelchair fell backward. Resident R174 subsequently landed on his/her back (inside the van) with the front wheels of the wheelchair in the air.Review of the statement by van driver, Employee E6, dated May 28, 2025, revealed Resident R174 was in his/her wheelchair and lifted onto the ramp to the bus and as van driver, Employee E6, walked around to the passenger door Resident R174 pulled the wheelchair brakes and he/she fell backward, hitting his/her head on the side of the bus. Continued review of statement by van driver, Employee E6, dated May 28, 2025, revealed Resident R174 often felt the need to help so when getting him/her on or off the bus he/she would push the brake. Van driver, Employee E6, reported to always redirect the resident to allow the driver to release the brakes. A tour of the facility van was conducted on September 18, 2025, at 12:25 p.m. with van driver, Employee E6. Observations revealed the van had a side-loading wheelchair ramp. The van was equipped with a ramp on the back, right side of the van that lowers to the ground to allow residents with wheelchairs to be rolled onto the ramp and lifted into the van. Interview on September 18, 2025, at 12:25 p.m. with van driver, Employee E6, revealed when picking up Resident R174 from his/her appointment on May 28, 2025, the van was parked on a slight slant due to the curve of the road. Van (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	driver, Employee E6, loaded Resident R174 onto the wheelchair ramp with his/her wheelchair facing away from the van. Van driver, Employee E6, then lifted the ramp off the ground to be parallel with the van. Van driver, Employee E6, left Resident R174 unattended on the raised lift to enter the van from the front so he/she could continue backing the resident into the van. As van driver, Employee E6, walked away, Resident R174 released his/her wheelchair brakes and fell backwards into the van. Continued interview on September 18, 2025, at 12:25 p.m. with van driver, Employee E6, revealed Resident R174 did not appear to have any injuries so the resident was assisted back into the wheelchair and brought back to the facility for further assessment by nursing staff. Further interview on September 18, 2025, at 12:25 p.m. with van driver, Employee E6, revealed he/she would typically stay on the lift with the resident when being assisted into the van but due to the slant of the van the employee was nervous to stay on the ramp. The van driver, Employee E6, explained that Resident R174 often needed reminders not to release his wheelchair brakes as this is the responsibility of the van driver to ensure safety. 28 Pa. Code 211.10 (d) Resident care policies. 28 Pa. Code 211.12 (d)(5) Nursing services.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical records, and staff interviews it was determined that the facility failed to monitor and modify interventions consistent with the resident's assessed needs to maintain acceptable parameters of nutritional status for one of five residents reviewed (Resident R142).Findings Include: Review of facility policy Weights and Heights dated July 15, 2025, revealed the facility will ensure all patients maintain acceptable parameters of nutrition status. Review of Resident R142's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated July 21, 2025, revealed the resident was admitted to the facility on [DATE], had diagnoses of diabetes mellitus (metabolic disorder that results in elevated blood sugar levels), hypokalemia (low potassium blood levels) gastroesophageal reflux disease (GERD - when stomach acid flows back into the esophagus) and dysphagia (difficulty swallowing).Continued review of Resident R142's MDS revealed his/her weight was coded as 199 pounds, was noted to have a weight loss of 5% or more in the last month of weight loss of 10% or more in the last month and was not a physician prescribed weight loss regimen.Review of Resident R142's comprehensive care plan revised August 8, 2025, revealed the resident was at nutritional risk related to diagnoses and abnormal weight loss.Review of Resident R142's clinical record revealed a comprehensive nutrition assessment dated [DATE], that assessed the resident's needs based on a recorded weight of 198.6 pounds. Continued review of Resident R142's nutrition assessment revealed the resident had a significant weight loss over six months (10.2% weight loss since January 8, 2025).Further review of Resident R142's nutrition assessment dated [DATE], revealed the resident had no noted edema at the time of assessment. Goals through the next review included weight to remain within usual body weight range without significant weight changes. Per the assessment, monitoring of the resident included monitoring of weights and PO (by mouth) intakes.Review of Resident R142's weight history revealed a documented weight on July 21, 2025, of 198.6 pounds and a documented weight on July 23, 2025, of 188.8 pounds which reflected a 9.8 pound / 4.9% significant weight loss in two days. The weight loss was confirmed/sustained with a documented weight of 189 pounds on August 13, 2025.Continued review of Resident R142's weight history revealed the weight loss was sustained and continued to trend down to 179.6 pounds on September 17, 2025, which reflected another significant weight loss of 9.4 pounds / 5% in one month.Review of Resident R142's entire clinical record revealed no documented evidence that Resident R142's weight loss from July 23, 2025, and onward was identified and assessed. Interview on September 18, 2025, at 10:26 a.m. with Registered Dietitian, Employee E9, confirmed there was no follow-up to address Resident R142's significant weight loss.28 Pa. Code 211.10 (d) Resident care policies. 28 Pa. Code 211.12 (d)(5) Nursing Services.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, staff interviews, clinical record review, and review of facility policy, it was determined that the facility failed to ensure that a resident was provided with dialysis clamps for one of one resident reviewed receiving hemodialysis. (Residents 15).Findings include:Facility policy titled Dialysis: Hemodialysis (HD) - external catheter valuation and maintenance, last date revised December 16, 2024, stated under 2. Maintain two smooth edged clamps with the patient at all times. 2.1 Smooth edged clamps must be placed at the bedside at time of admission. 2.2 Smooth edged clamps are to be attend to the patient's clothing during transport to and from dialysis facility or for any appointment(s) outside the nursing center. 2.3 If patient is mobile throughout the Center, smooth edged clamps must be attached to the patient's clothing at all times.Review of Resident R15's clinical record indicated an admission date of June 15, 2025, with diagnosis of end stage renal disease, and anima in chronic kidney disease. Review of July 2025 physician orders revealed an order dated, July 25, 2025 monitor hemodialysis site on dialysis days, pre and post during dialysis days, Monday, Wednesday, and Friday and document. Pre and Post dialysis assessment documented. On dialysis days. Monitor hemodialysis LFA site for signs/symptoms of complications (e.g, bleeding, swelling, pain drainage, odor, hardness or redness at site), Notify the physician and dialysis center immediately with any urgent problems.On September 18, 2025, at 10:32 a.m., an interview was conducted with Licensed Nurse, Employee E4, who confirmed that Resident R15, a dialysis patient, should have clamps either at his bedside or in his wheelchair. Observations were made in Resident R15's room, and no clamps were found at the bedside. Employee E4 then stated that the clamps were located in Resident R15's wheelchair.Observations conducted at the above time with Licensed nurse, Employee E4 of Resident R15 revealed that Resident R15 was in the dining room seated in (his/her) wheelchair at an activity. Resident R15 reported that (his/her) clamps were in the wheelchair; however, upon being asked by Employee E4 to locate them, none were found. After Resident R15 stood up, Employee E4 confirmed that no dialysis clamps were present.Interview conducted on September 18, 2205 at 12:23 p.m., with the Nursing Home Administrator, Employee E1, and the Director of Nursing, Employee E2. confirmed that dialysis clamps are required to remain with the resident at all times.28 Pa. Code 211.12 (d)(1)(5) Nursing Services