STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395485	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accelerate Skilled Nursingandrehabilitation Phila	1526 Lombard Street Philadelphia, PA 19146

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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609 Based on review of clinical records, facility documentation and interviews with staff, it was determined the facility did not ensure proper supervision for one of three residents reviewed (Resident R1). Findings include: Review of Resident R1's clinical record revealed the resident was alert and oriented able to make life decisions and was his own responsible party. The resident was admitted to the facility on [DATE], diagnosed with Diabetes (body is not able to produce insulin resulting in high levels of sugar in the blood), fractured mandible (jaw) and malnutrition (Lack of sufficient nutrients in the body). Review of facility documentation revealed on May 28, 2024, Nurse's Aide (NA) Employee E3 who worked on the 3-11 pm shift made her rounds at 3:30 p.m. and discovered Resident R1 was not in his room and his tray from lunch was still there. At dinner time (approximately 5:30 p.m.) the aide asked the Licensed Practical Nurse (LPN) Employee E4 about Resident R1 since she had not seen him. The LPN indicated in her witness statement that she last saw Resident R1 at approximately 2:00 p.m. in his wheelchair propelling towards the elevator. Interview with NA Employee E3 on June 20, 2024 at 3:00 p.m. stated at first I did not think much of it when the resident wasn't in his room. Residents go out on appointments or go outside. When the NA did not see him at dinnertime that is when she asked his nurse. Further review the facility's investigation and interview with the Director of Nursing on June 20, 2024, at approximately 1:30 p.m. determined 3 1/2 hours past before the resident was last seen. The Director of Nursing stated all nursing staff are required to make rounds on the units at least every two hours to ensure resident safety and all nursing staff are to report any issues to the unit manager, Director of Nursing and /or the Assistant Director of Nursing in a timely manner, 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