STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395545	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accela Rehab and Care Center at Springfield	850 Papermill Road Glenside, 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 43277 Based on review of facility policy, review of facility documentation, and staff interview, it was determined that the facility failed report the results of abuse, neglect, and misappropriation investigations within 5 working days to the State Survey Agency, as required, for four of four residents reviewed (Resident R1, R2, R7, and R8). Findings Include: Review of facility policy Abuse and Neglect - Clinical Protocol, revised March 2018, revealed the management and staff, with physician support, will address situations of suspected or identified abuse and report them in a timely manner to appropriate agencies, consistent with applicable laws and regulations. Review of documentation submitted by the facility on September 30, 2024, to the State Survey Agency via the Event Reporting System (electronic database that collects reports of resident events from healthcare facilities), revealed on September 27, 2024, Resident R7 reported to facility staff that money was taken from his personal bag that was hanging on his wheelchair. The facility subsequently initiated an internal investigation to rule out misappropriation of resident property. Review of documentation submitted by the facility on October 2, 2024, to the State Survey Agency via the Event Reporting System, revealed on October 2, 2024, Resident R1 alleged getting into a verbal altercation with the facility van driver. The facility subsequently initiated an internal investigation to rule out resident abuse. Review of documentation submitted by the facility on October 28, 2024, to the State Survey Agency via the Event Reporting System, revealed on October 24, 2024, Resident R2 alleged neglect saying that he had not received showers or snacks. The facility subsequently initiated an internal investigation to rule out resident neglect. Review of documentation submitted by the facility on December 17, 2024, to the State Survey Agency via the Event Reporting System, revealed on December 16, 2024, Resident R8's family member alleged nurse aides were rough with Resident R8 when providing care. The facility subsequently initiated an internal investigation to rule out resident abuse. (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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per a thorough review of documentation submitted by the facility to Event Reporting System, revealed no documented evidence that the facility reported the results/outcomes for the above investigations to the State Survey Agency as required for Residents R1, R2, R7, and R8. 28 Pa. Code 201.14 (a) Responsibility of licensee.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277 Based on review of facility policy, review of clinical records, and staff interview, it was determined that the facility failed to provide evidence of a Level 1 pre-screening for mental disorders/intellectual disabilities for one of two residents reviewed (Resident R1). Findings Include: Review of facility policy Admission Criteria, revised March 2019, revealed the facility only allows admissions of residents who's medical and nursing care needs can be met. Continued review of facility policy Admission Criteria revealed all new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID or RD. Review of Resident R1's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated January 5, 2025, revealed the resident was admitted to the facility on [DATE], and was cognitively intact. Further review of Resident R1's MDS dated [DATE], revealed the resident had diagnoses of post-traumatic stress disorder (PTSD - a mental and behavioral disorder that develops from experiencing a traumatic event), schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior), and depression (a mood disorder that causes persistent feelings of sadness). Review of Resident R1's clinical record revealed a physician order dated December 2, 2024, for Duloxetine 30 milligrams per day (mg/day) for antidepressant, and a physician order dated December 23, 2024, for Seroquel 50 mg/day for bipolar (serious mental illness characterized by extreme mood swings). Review of Resident R1's entire clinical record revealed no documented evidence the facility conducted a Level 1 PASARR screen for Resident R1. Interview on January 28, 2024, at 2:45 p.m. with the Nursing Home Administrator, Employee E1, confirmed the facility was unable to provide evidence of Resident R1's Level 1 PASARR screen. 28 Pa. Code 211.5 (f)(iv) Medical records. 28 Pa. Code 211.10 (c) Resident care policies.

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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 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277 Based on review of facility documentation, review of clinical records, and resident and staff interviews, it was determined that the facility failed to maintain agreements pertaining to services furnished by outside resources. Findings Include: Review of Resident R1's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated January 5, 2025, revealed the resident was admitted to the facility on [DATE], and was cognitively intact. Further review of the MDS revealed Resident R1 had diagnoses of post-traumatic stress disorder (PTSD - a mental and behavioral disorder that develops from experiencing a traumatic event), schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior), and depression (a mood disorder that causes persistent feelings of sadness). Interview on January 25, 2025, at 9:35 a.m. Nursing Home Administrator, Employee E1, and Assistant Nursing Home Administrator, Employee E3, revealed that the facility utilized Uber services (web-based app that connects drivers (who utilize personal vehicles) and riders on demand for transportation services) to transport Resident R1 to and from appointments. Interview on January 28, 2025, at 11:40 a.m. Resident R1 expressed concerns regarding the use of Uber transportation for appointments. Resident R1 reported that the Uber does not drop him off or pick him up in the right locations causing Resident R1 to walk short distances. Resident R1 also reported having to wait long periods of time for the Uber to arrive after appointments. Phone interview on January 29. 2025, at 1:50 p.m. with the Nursing Home Administrator, Employee E1, revealed the facility is equipped with its own van and staffed van drivers to transport residents to and from appointments. Further interview revealed the facility also has an agreement in place with a contracted transport company to transport residents who require the use of a stretcher. Review of documentation provided by the Nursing Home Administrator, Employee E1, revealed a transport agreement with [Contracted Ambulance Service] for medical transportation services dated March 1, 2022. Review of the transport agreement revealed the agreement was signed by facility administration on February 24, 2022, however, was never signed by [Contracted Ambulance Service]. Phone interview on January 29, 2025, at 3:30 p.m. with the Nursing Home Administrator, Employee E1, also revealed the facility did not have a transport agreement with Uber. 28 Pa. Code 201.14 (a) Responsibility of licensee.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277 Based on observations, and resident and staff interviews, it was determined that the facility failed to maintain a safe, functional, sanitary, and comfortable environment for residents and staff for three of four nursing units toured (1 Pavilion, 2 Pavilion, and 2 Main). Findings Include: During an interview on January 28, 2025, at 9:25 a.m. with Resident R3 and R4, the residents reported the sink next door (room [ROOM NUMBER]) was clogged causing the sink to overflow and subsequently flood into their room (room [ROOM NUMBER]). Resident R3 and R4 reported it has happened 4-5 times over the last few weeks. Observations revealed rooms [ROOM NUMBERS] were conjoined by a shared bathroom. room [ROOM NUMBER] and room [ROOM NUMBER] were each equipped with its own sink in the room. Observations on January 28, 2025, at 9:30 a.m. confirmed the sink in room [ROOM NUMBER] was clogged. When surveyor turned on the sink in room [ROOM NUMBER], the sink quickly began to fill up with water. Observations of the clogged sink were confirmed by nurse aide, Employee E4. Interview on January 28, 2025, at 11:30 a.m. with Licensed Nurse, Employee E5, confirmed room [ROOM NUMBER] flooded multiple times, over the last couple weeks, due to the sink in room [ROOM NUMBER] being clogged. The Licensed Nurse, Employee E5, explained that a nurse turned on sink in room [ROOM NUMBER] and walked away, causing the sink to overflow and flood the room. A remaining tour of the facility was conducted on January 28, 2025, at 10:30 a.m. with the Assistant Administrator, Employee E3, which revealed the following: During a tour of the 1 Pavilion nursing unit, the overbed table in room [ROOM NUMBER] (B-Bed) was visibly soiled at the base of the table. Continued observations in room [ROOM NUMBER] revealed the bed enabler for the A-Bed was broken and hanging off the bed. Observations of the kitchenette on the 1 Pavilion nursing unit revealed one of the doors for the cabinets was missing. The toilet in the shower room on 1 Pavilion nursing unit was visibly soiled with brown stains. Observations in room [ROOM NUMBER] revealed the sink handle was missing, and the bathroom had no toilet paper holder. During a tour of the 2 Pavilion nursing unit revealed Resident R5 was sitting in the hallway using an overbed table that was visibly soiled at the base of the table. During a tour of the 2 Main nursing unit revealed Resident R6 was in bed, room [ROOM NUMBER]-D, and the foot board of the bed was broken and falling off. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations in room [ROOM NUMBER] revealed the sink in bathroom was taken off the wall leaving a hole in the wall. Assistant Administrator, Employee E3, confirmed the facility had yet to replace the sink in the bathroom. The above observations were confirmed throughout the duration of the tour of the facility with Assistant Administrator, Employee E3. 28 Pa. Code 201.14 (a) Responsibility of licensee.