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	05/08/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, family and staff interview, it was determined that the facility failed to ensure that the resident's representative was notified timely about a residents fall with injury for one of 18 residents reviewed (Residents R4). Findings include: A review of clinical records revealed that Resident R4 was admitted to the facility on [DATE], for short time rehabilitation after a fall at an assisted living facility. Further review revealed a nursing note written by licensed nurse, Employee E16, stating that on April 18, 2025, Resident R4 was found on the floor. The Hoyer lift (mechanical lift) was used along with two nurse aides to help the resident to bed. The registered nurse supervisor informed Employee E16 that she would make the follow up contact to the physician and the resident's responsible party. An interview with the Director of Nursing (DON) on May 7, 2025, at 11:20 a.m. confirmed that the nursing notes did not indicate that the daughter, who is Resident R4's responsible party, was notified of the resident's fall and that the note stated that the nurse supervisor was to call the responsible party. The DON further stated that the nurse supervisor was terminated after Resident R4's fall investigation for not notifying the responsible party. A telephone interview with Resident R27's daughter, and responsible party, on May 12, 2025, at 1:30 p.m. revealed that she was upset about not being notified when the resident fell out of bed. That the resident was not able to stand up and get back into bed by herself, so that they must have picked her up and put her back into bed and she was obviously injured. 28 Pa. Code 211.12(d)(5) 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and resident and staff interviews, it was determined that the facility failed to maintain the facility in a clean, safe, comfortable and homelike condition in two of nursing floors (1st and 2nd floor). Findings include: Observations on May 6, 2025, at 9:50 a.m., on the first floor main near the nurse's station and room [ROOM NUMBER] revealed a strong odor of urine. Interview with the Director of Nursing (DON) on May 6, 2025, at 9:54 a.m., on the first floor main near the nurse's station confirmed that she smelled the heavy odor of urine. Interview with the Administrator (NHA) on May 6, 2025, at 10:05 a.m., during a tour of the first floor confirmed the smell of urine near the nurse station and room [ROOM NUMBER], and the door handle on the inside of the door to the stairwell was missing and the opening was sharp and the only way to open the door from the inside of the stairwell was to reach into the hole to hold the door. Observations on May 6, 2025, at 10:53 a.m., in the bathroom in room [ROOM NUMBER] revealed that the sink was off the wall and sitting on the floor, and that the floor in the walk-in shower was very dirty. A a soiled incontinent brief was observed in a wash basin sitting on the floor of the shower. The bathroom smelled of the dirty brief. Interview on May 6, 2025, at 10:55 a.m., with Employee F9, nurse aide assigned to room [ROOM NUMBER], confirmed the above findings in the bathroom of room [ROOM NUMBER] after a tour of the room. Interview on May 6, 2025, at 10:58 a.m., with Employee F10, Environmental Services Director, during a tour of room [ROOM NUMBER] confirmed the above findings in the bathroom and stated that he would talk to the maintenance department about the sink and drain cover. Employee E10 also stated that the walk-in shower should be closed off as the resident on this floor are confused and are not able to use the shower unsupervised and did not need to be wandering into this area. 28 Pa. Code 207.2(a) Administrator's responsibility

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and resident and staff interviews, it was determined that the facility failed to ensure that wound care was performed per physician orders for one of 18 residents reviewed (Resident R3). Findings include: Review of Resident R3's clinical records revealed that the resident was admitted on [DATE], with diagnosis including generalized weakness and abnormalities of gait and mobility (when a person walks differently due to injuries, conditions, or issues with the legs or feet). An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident R3, dated April 1, 2025, revealed that the resident was understood and could understand. Review of Resident R3's physician order revealed a December 23, 2024, order to cleanse right and left buttock with Dyna-Hex4, apply triamcinolone cream to 6x6 foam dressing and apply to wound bed. And a December 23, 2024, order to cleanse groin with Dyna-Hex4, and a July 9, 2024, order to apply triamcinolone cream to groin and place an abdominal pad 8 to groin. Interview with Resident R3 on May 7, 2025, at 1:20 p.m. revealed that when the regular wound nurse is off, he does not usually get wound care. Resident R3 stated that they don't like him and so they don't even ask him if they can change his wounds. He said that is mostly agency and that they don't care. A review of Resident R3's Treatment Administration Report (TAR) for April 2025 revealed no documented evidence that special wound cleanser (Dyna-Hex4) was applied to both buttocks and groin, as well as medicated pad to the buttocks wounds and pad to the groin wound,on 4/20/2025; 4/22/2025; 4/23/2025; 4/24/ 2025, 4/29/2025 and 4/30/2025. Interview with the wound nurse, Employee E6, at 1:05 p.m. on May 6, 2025, revealed that she was on vacation during these days when Resident R3's would care was not completed. When she looked at the TAR for Resident R3 she said that the days that were empty would mean that the wound care treatment was not done. Interview with the Director of Nursing on May 7, 2025, at 10:15 a.m. confirmed that wound care was not performed on Resident R3 on six dates in April 2025 when the wound nurse was on vacation. 28 Pa. Code 211.12(d)(5) 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policy and interviews with staff, it was determined that the facility failed to ensure that a safe environment was maintained related to exposed sharp edges, tripping hazards and a syringe being left unattended on a medication cart on two of four nursing units. (First floor and Second floor) Findings include: Review of the Administering Medications policy revised April 2019, revealed that during administration the cart must be closed and locked when out of sight of the medication nurse, and that no medications are kept on the top of the cart. Interview with the Administrator (NHA) on May 6, 2025, at 10:05 a.m., during a tour of the first floor confirmed that the door handle on the inside of the door to the stairwell was missing and the opening was sharp and the only way to open the door from the inside of the stairwell was to reach into the hole to hold the door, a potentially dangerous situation. Interview on May 6, 2025, at 10:58 a.m., with Employee F10, Environmental Services Director, during a tour of room [ROOM NUMBER] confirmed the potentially dangerous situation in the walk-in shower which has a lower shower floor, which may cause a confused resident on this locked unit to fall into the shower. The shower also in missing the cover to the drain revealing a sharp edge and an open pipe which the confuse residents were packing full of markers and debris. Employee E10 stated that the walk-in shower should be closed off as the resident on this floor are confused and are not able to use the shower unsupervised and did not need to be wandering into this area. Employee E10 also confirmed that the sink in room [ROOM NUMBER]'s bathroom was pulled off the wall and sitting on the floor causing a tripping hazard for the ambulatory residents in this room who are very confused. Observations on May 6, 2025, at 11:10 a.m., on the first floor main between the nurse's station and the stairwell revealed a hypodermic syringe sitting on top of a medication cart with no nurse within eyesight of the cart. Further observation revealed the Director of Nursing (DON) was around the corner on her cell phone. When asked what was wrong with the medication cart she confirmed that the insulin syringe should not have been left on top of the cart unattended. During the interview with DON, Employee E8, at the time of the above observation licensed nurse returned to her cart and the DON pointed out the syringe and told her to take a deep breath and collect herself and continue with medication pass paying closer attention. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observations, resident and staff interviews, and a review of facility documentation, it was determined that the facility has failed to provide meals at regular times each day. Findings include: Interview with Administrator (NHA) on May 6, 2025, at 9:05 a.m. revealed that there was a sewage backup in the kitchen which caused the County Health Department to shut the kitchen down in the middle of preparing for lunch and all the food had to be discarded. This did cause the meal to be late until facility staff could arrange meals to purchase. Interview with the Food Service Director (FSD), Employee E11, on May 6, 2025, at 9:15 a.m. confirmed that the County Health Department made them destroy all the food that was to be served for lunch when the kitchen was contaminated with a sewage backup and that the lunch meal was hoagies from a local fast food place which was not delivered until at 3:45 p.m. Interview with Resident R11 at 10:30 a.m. on May 6, 2025, revealed that she was still waiting for breakfast, and that yesterday they waited all afternoon until 4 p.m. for lunch when they got a hoagie. Interview with Resident R12 at 10:33 a.m. on May 6, 2025, revealed that she and her roommate, who is a diabetic are still waiting for breakfast, and that at 10:30 a.m. she got a sandwich from the nurse for her roommate as really needs to have her meals on time to avoid passing out from low blood sugar. She said that yesterday her breakfast was late again and that she got cereal with no milk and she had to put water in it to eat it. She said that yesterday she did not get lunch until after 4:00 p.m. when she got a hoagie. Interview with Resident R13 at 10:40 a.m. on May 6, 2025, revealed that he had just received his breakfast, and that yesterday he got a hoagie for lunch around 4:00 p.m. Interview with Resident R14 at 10:42 a.m. on May 6, 2025, revealed that her breakfast was late today, and that yesterday she did not get lunch, just macaroni and cheese until after 4:00 p.m. Interview with Resident R15 at 10:44 a.m. on May 6, 2025, revealed that her breakfast was late today and all she got was cold cereal and no juice. She said they never check her menu and they cut the meals short. Resident R15 stated that yesterday was a mess, no lunch until after 4:00 p.m. Interview with the FSD at 12:30 p.m. on May 6, 2025, revealed that lunch was purchased at a restaurant supply company and was being prepared at a sister facility which is about a half hour drive away. She said that they were packing it up and that it should be leaving the facility in the next few minutes. Observations in the main kitchen on May 6, 2025, at 1:25 p.m. revealed that the food was not delivered yet. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the [NAME] President of Operations for the food service management company, Employee E13, at 1:30 p.m. on May 6, 2025, confirmed that the food had just arrived at the facility. Observations in the main kitchen on May 6, 2025, at 1:33 p.m. revealed that the food was leaving the kitchen individually packed in brown paper bags in coolers for the floors. A review of the meal delivery times revealed that breakfast was to be served between 7:30 a.m. and 8:33 a. m. and lunch was to be served between noon and 12:45 p.m. depending on the nursing unit. Interview with Administrator (NHA) on May 7, 2025, at 2:05 p.m. confirmed that the facility did not serve lunch on May 6, 2025, or breakfast or lunch on May 7, 2025, within a reasonable time based on their meal schedule. 28 Pa. Code: 211.6(a) Dietary Services 28 Pa. Code: 201.18(b)(1) Management 28 Pa. Code: 201.14(a)(b) Responsibility of Licensee 28 Pa. Code: 201.29(a) Resident rights