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	05/28/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 review of facility policy, observations, interviews with residents and staff, it was determined that the facility did not ensure a clean, comfortable, and homelike environment in resident care areas for two of two nursing units observed (First Floor and Second Floor). Findings Include: Review of the facility policy titled, Homelike Environment revised February 2021 states, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Further review of the policy revealed 2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment; .e. clean bed and bath linens that are in good condition; f. pleasant, neutral scents. An initial tour was taken on May 28, 2025 at of the second-floor nursing unit at 9:21 a.m A tour was taken initially of the locked unit. After entering the unit there was black food debris scattered in the hallway on the floor. Observation of Resident R1's room at 9:23 a.m. revealed a bathroom that had a dirty soiled toilet and a shower stall that had paper trash and soiled sheets/towels in it. Resident R1's bed side dresser had a small piece of a blue/white pill. On the floor to the left of Resident R1's bed was white pill residue. Observation of Resident R2's room at 9:24 a.m. revealed a dresser drawer with mouse droppings in the top two drawers. Resident R2's floor had food debris and paper trash. There were two trash cans in the room with trash in them that had no plastic liners. These findings were confirmed by Licensed Nurse Employee E4 at 9:32 a.m. When asked if Resident R2 gets his medications crushed, Employee E4 stated that Resident R2's does not, he spits out his medications and needs to be watched to ensure he swallows them. Observation of Resident R3's room at 9:41 a.m. revealed the resident was in bed. The sheets on the bed were soiled with food stains and there was food debris on the bottom of the bed and on the floor around the bed. (continued on next page)

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 - Some	A tour was taken of the first floor nursing unit on May 28, 2025, at 9:45 a.m., an interview with Resident R8 revealed several concerns: the resident did not have a bedside dresser, the headboard was broken and lying on the floor, and there was a spill on the floor from a magic cup. Additionally, the resident's phone was found on the floor. The restroom in room [ROOM NUMBER] had a hole behind the toilet. room [ROOM NUMBER] had a strong odor of urine. These observations were confirmed by the facility Scheduler, Employee E7. Continued observations, at 12:13 p.m., a follow-up tour of the first floor nursing unit was conducted with the Director of Nursing, Employee E2. During this tour, the following issues were confirmed: - The bed in room [ROOM NUMBER]A was broken. - The headboard in room [ROOM NUMBER] was broken and on the floor. - In room [ROOM NUMBER], near the doorway, there were two boxes on the floor belonging to Resident R9. The boxes contained cleaning supplies, spices, and hygiene items. - There was no bedside dresser in the room, leaving the resident without a proper place to keep their telephone, which was found on the floor. Continued observation of the second floor nursing unit at 1:01 p.m. revealed Resident R5's room had paper trash and food debris scattered across the floor. Resident R5's trash can had no trash can liner and was nearly full with latex gloves, paper trash, and food debris that was disposed. On the floor next to the trash can were two used latex gloves. 28 Pa. Code 201.14 (a) Responsibility of licensee.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, interviews with staff and hospital staff, reviews of hospital records, electronic communication records and facility policies and procedures, it was determined that the facility failed to permit one of one resident reviewed to return to the facility after hospitalization. (Resident R12) Findings include: Review of the policy titled Bed Holds and Returns revised March 2022 revealed that Residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed-hold politicizes. All residents/representatives are provided written information regarding the facility bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization ortherapeutic leave). Residents are provided written information about these policies at least twice: a. well in advance of any transfer (e.g., in the admission packet); and b. at the time of transfer (or, if the transfer was an emergency, within 24 hours). 2. Reissuance of the notice is provided if there are changes made to the bed-hold policy under the state plan or facility policy. 3. The written information regarding bed-holds provided to the residents/representatives explains in detail: a. the duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the facility; b. the reserve bed payment policy as indicated by the state plan (for Medicaid residents); c. the facility policies regarding bed-hold periods; d. the facility per diem rate required to hold a bed (for non-Medicaid residents), or to hold a bed beyond the state bed-hold period (for Medicaid residents); and e. the return policy. 4. Medicaid residents who exceed the state's bed-hold limit and/or non-Medicaid residents who request a bed-hold are responsible for the facility's basic per diem rate while his or her bed is held. 5. If a Medicaid resident exceeds the state bed-hold period, he or she will be permitted to return to the facility, to his or her previous room (if available) or immediately upon the first availability of a bed in a semi-private room provided that the resident requires the services of the facility and is eligible for Medicare skilled nursing services or Medicaid nursing services. 6. If the resident is transferred with the expectation that he or she will return, but it is determined that the resident cannot return, that resident will be formally discharged . 7. The resident will be permitted to return to an available bed in the location of the facility that he or she previously resided. If there is not an available bed in that part, the resident will be given the option to take an available bed in another distinct part of the facility and return to the previous distinct part when a bed becomes available. Review of Resident R12's clinical record revealed that Resident R12 was admitted to the facility on [DATE], with diagnosis of schizoaffective disorder (mental condition that combines symptoms of schizohrenia and mood disorders), depression (major loss of interest in pleasurable activities), bipolar disorder (condition in which a person has periods of depressiona nd periods of being extremely happy), post-traumatic stress disorder (PTSD- mental condition that developes after experiencing a traumatic event). The nursing note dated May 13, 2025, at 3:29 p.m. indicated, that due to patient physical/verbal aggression towards staff and residents and unpredictability of patient's behavior, patient refusal to take anti-psych medication, patient transferred to local hospital via 302 (involuntary admission) with police present in facility at time of transfer. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing note dated May 13, 2025, at 9:31 p.m. indicated, that with the resident was transferred to the local hospital. Patient not expected to return to facility on 5/13/2025. Review of discharge Miniman Data Set (MDS- assessment of resident care needs) dated May 13, 2025, for Resident R12 revealed that the resident was discharged and return to the facility was anticipated. On May 28, 2025, at 11:42 a.m., an interview with the Director of Nursing, Employee E2, revealed that the local hospital notified the facility on May 15, 2025, that Resident R12 had been cleared for return. However, documentation shows that the facility did not permit the resident to return until May 20, 2025, resulting in a five-day delay. On May 28, 2025, at 1:40 p.m., an interview with the Administrator, Employee E1, revealed that on May 15, 2025, the local hospital contacted the facility to report that psychiatric findings had determined Resident R12 did not require admission to the psychiatric unit; therefore, did not meet the criteria and was ready to be returned to the facility. On May 16, 2025, the facility requested that the hospital continue to hold Resident R12 until Monday, May 19, 2025, in order to allow time to seek an alternative placement, as the resident had expressed a preference to transfer to a different facility while being at the hospital. On May 29, 2025, at 3:49 p.m., an interview was conducted with the Case Management Director at the hospital. The Case Manager stated that the facility had denied readmission for Resident R12. According to the hospital records, Resident R12 was medically cleared and ready to return to the facility on May 15, 2025. A call was placed to the facility's Director of Nursing, Employee E2, and the Administrator, Employee E1, who indicated they wanted to speak with the psychiatrist who had cleared the resident for return. A call was placed by the hospital to the treating psychiatist. A follow-up call was made by the hospital on May 15, 2025. During that call, the facility operator reportedly stated, I'm telling you, we're not taking him back. Hospital staff then requested a return call from either the Director of Nursing or the Administrator. Later that same day, the facility's Regional Director returned the call and asked the hospital to keep Resident R12 for few days, to allow the facility time to make staffing arrangements. On May 16, 2025, hospital staff informed Resident R12 that the facility was refusing to accept his return. At no point did Resident R12 refuse to return to the facility. The facility ultimately accepted Resident R12 back on May 20, 2025, resulting in a five-day delay from the date he was medically cleared for discharge. On May 28, 2025, at 2:25 p.m., the Administrator confirmed that the facility had received a notice of Resident R12's anticipated return on May 15, 2025. However, the facility did not permit the resident to return until May 20, 2025, resulting in a five-day delay. 28 PA. Code 201.14(a)(b) Responsibility of licensee 28 PA. Code 201.29(c.3)(4) Resident rights 28 PA. Code 211.12(d)(1) Nursing services

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observations, and resident and staff interviews, it was determined that the facility failed to honor resident food and drink preferences by providing food that was requested by and acceptable to the residents for 3 of 13 residents reviewed (Residents R10, R8, R13). Findings include: On May 28, 2025, at 9:20 a.m. during the initial tour of the 1st floor Pavilion nursing unit, it was observed that residents did not receive their coffee beverage. Residents' trays had juice on their trays, but there were no hot beverages. During a random room tour, it was observed that breakfast trays remained on bedside tray tables in Rooms 124 through 138. However, there was no evidence of hot beverage cups containing hot beverages on any of the trays. On May 28, 2025, at 9:33 a.m., an interview was conducted with Resident R13, who reported that her egg omelet was burned and that she was still hungry. She also stated that she prefers coffee as her morning hot beverage, but no coffee was provided on her breakfast tray. At the surveyor's request, the resident pressed the call bell. In response, Nursing Assistant Employee E9 entered the room and explained that she had already requested coffee from the kitchen an hour earlier, but it had not yet been delivered. Resident R13 informed Employee E9 that her omelet was burned and requested a new breakfast tray. Employee E9 responded by stating, All the omelets were burned, and they will not give you a new plate, but you will receive the same breakfast plate as you had. On May 28, 2025, at 9:39 a.m., Employee E9 reported that Resident R10 had not yet received his breakfast because his bed was broken and could not be adjusted to raise the head section. As a result, she needed to transfer the resident into a wheelchair before he could eat his now-cold breakfast. Employee E9 stated that she had ordered a new breakfast tray for Resident R10. On May 28, 2025, at 9:40 a.m., an interview was conducted with Resident R8, who reported that a staff member entered his room and removed his breakfast tray before he had finished eating. Resident R8 stated that he still needed to finish his Magic Cup supplement and Ensure drink. Scheduler Employee E7, who was assisting the nursing unit with tray collection, confirmed that Resident R8 is prescribed both Magic Cup and Ensure as dietary supplements. Further, Scheduler, Employee E7 confirmed that dietary aide brought two pitchers of coffee but there were not hot beverage cups available to pour them in. On May 28, 2025, at 10:01 a.m., a kitchen tour was conducted with Dietary Assistant Employee E6. Employee E6 confirmed that the omelets served that morning were burned due to sticking to the metal serving container, and that these were served to all residents. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It was further revealed that the facility lacks adequate hot beverage cups to serve hot drinks. All six breakfast delivery trucks were returned from the nursing units; only six hot beverage cups were observed in total, despite a facility census of 120 residents. Employee E6 stated that the kitchen has approximately 20 hot beverage cups in total and that the Dietary Director has repeatedly requested that the facility order more. Additionally, a review of the dry storage area revealed small Styrofoam cups without lids. On May 28, 2025, at approximately 11:47 a.m., the Administrator, Employee E1, confirmed that the facility was out of hot beverage cups and that an order had been placed. However, when asked to provide documentation-such as receipts or the order date-to verify the purchase, the facility did not provide the requested information. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to implement enhanced barrier precautions for one of two residents reviewed who had a peripherally inserted central catheter (PICC) line. (Resident R12). Findings Include: Review of facility policy Isolation- Categories of Transmission -Based Precautions revised October 2018, revealed transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; pr has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. Under bulletin #5. When a resident is placed on transmission-base precautions, appropriate notification is plced on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precautions. The signage informs the staff of the type of CDC precautions, instruction for use of PPE, and/or instructions to see a nurse before entering the room. A review of Resident R12's clinical record revealed that the resident was admitted to the facility on [DATE] with diagnosis of hidradenitis suppurative (chronic inflammatory skin condition characterized by painful lumps that form under the skin), muscle weakness, abnormalities of gait and mobility, chronic pain, need for assistance with personal care, unspecified convulsions. Review of Resident R12's Medication Administration Report (MAR) for the month of May 2025 revealed a resident had a peripherally inserted central catheter PICC line dated May 5, 2025. Resident R12 also had multiple wound that were getting treated. A review of the comprehensive care plan created February 15, 2025, for enhanced barrier precautions related to right ad left buttock wounds. On May 28, 2025, at 12:13 p.m., an interview and observation with the Director of Nursing, Employee E2, confirmed that Resident R12 is on Enhanced Barrier Precautions due to a PICC line and the presence of wounds. However, there was no Enhanced Barrier Precaution signage on Resident R12's door, and no gowns were readily available outside the room. 28 Pa. Code 211.10 (d) Resident care policies. 28 Pa. Code 211.12 (d)(5) Nursing services.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, resident and staff interviews, review of the pest control logs and the pest control reports and documentation, it was determined that the facility failed to maintain an effective pest control program for one of two nursing units and the kitchen area. (Second Floor Nursing Unit and Kitchen Area) Findings Include: A tour was taken on May 28, 2025 at 9:21 a.m. of Resident R2's room and the resident was visualed sleeping in bed. Observation was made of two bed side dressers for the resident. The resident had a small nightstand dresser to the right of his bed that had a broken bottom drawer. Upon opening the drawer there was a plastic bag with opened food including cookies and nuts. A review of Resident R2's clinical record revealed the resident was admitted to the facility on Feburary 4, 2025 with the following diagnsoses; Dementia with agitation, Anxiety Disorder, and Major Depressive Disorder. Further review of Resident R2's clinical record revealed a MDS (Minimum Data Set- assessment of resident's needs) completed on admission on [DATE] that listed the resident ability to make decisions regarding tasks of daily life as severly impaired. Further observation was made of one large size dresser next to the window in the room and the dresser did have mouse droppings in the top two drawers of the bedside table closest to the window. Licensed Nurse E4 came into the room at 9:32 a.m. and confirmed the above findings. Employee E4 stated that Resident R2's family member comes in to visit at times and brings food and they won't know about it. Review of facility grievance log revealed a grievance for Resident R2 on May 19, 2025 stating Summary of Grievance, States she was in her husbands drawer on his dresser where she keeps his snacks. States there was mouse droppings in drawer and all food bags were chewed through. Wife states, it's absolutely ridiculous and disgusting and [she will be reaching out to other outlets also]. Summary of Pertient Findings or Conclusion lists, Housekeeping Department personally cleaned room and nightstand furniture. The Summary box at the bottom of the grievance is mostly blank. The only portion that is filled in is checked off Issue Resolved. Review of Pest Control reports revealed dated April 23, 2025 revealed, Checked in with staff. Inspected and treated the kitchen for roaches. Treated drains, baited voids, underneath tables, carts and placed insect monitors. Excessive roaches observed coming in from the wall along the dishwasher machine. Poor sanitation throughout the kitchen. Recommend adding a roach clean out service. Also recommend deep cleaning the kitchen, appliances, behind the appliances, etc. please refer to pictures sent. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Pest Control reports revealed dated May 19, 2025 revealed, Checked logbooks, no reports. Inspected and treated lobby areas, nurse stations, and break room for occasional invaders. Inspected and treated kitchen areas for occasional invaders. Spoke with the cook who said after the big flood they have been experiencing roach activity. Treated heavily throughout the kitchen, baited as needed and updated monitors as needed. The current monitors throughout the kitchen had no roach acceptance. No activity seen during service. Review of pest control logs revealed the facility did have a recent concern with mice and roaches in the building, May 19, 2025, Mine-room [ROOM NUMBER]-2 main May 19. 2025, Mice-1 main May 24, 2025, Resident-212. For the three spots mentioned the location of application, pesticide used, and notes section are all left blank and not filled in to completion. A tour was taken of the kitchen and dumpster area on May 28, 2025 at 11:35 a.m. with Dietary staff, Employee E6 Interview held the Nursing Home Administrator Employee E1 on May 28, 2025 at 2:12 p.m. regarding the Pest Control schedule. When asked if the Pest Control company comes out bi-weekly Employee E1 stated, I believe that is correct, when asked to confirm that the Pest Control company has not been onsite since May 19, 2025 when mice were reported on the second floor Employee E1 stated, I need to confirm but yes I believe they have not. Review of Pest Control reports revealed the facility has had concerns with mice and roaches during the months of April 2025 and May 2025. Review ofthe Service Inspection Reports, the company has not been out to the facility to treat for pests since May 19, 2025. Further investigation of the dumpster area revealed there was trash around and in front of the dumpster area including paper trash, food, and dirt. 28 Pa Code 201.18(a)(b)(1) Management 28 Pa Code 201.14(a) Responsibility of licensee