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	06/12/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon review of facility policies and procedures, review of clinical records and facility documentation and interviews with staff, it was determined that the facility did not ensure that a complete and thorough investigation was completed to rule out neglect for one of four fall investigations reviewed (Residents R1). Findings include: Review of the facility's policy revised April 2021, titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, which states, The individual conducting the investigation as a minimum: a. reviews the documentation and evidence; b. reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; c. observes the alleged victim, including his or her interactions with staff and other residents; d. interviews the person(s) reporting the incident; e. interviews any witnesses to the incident; f. interviews the resident (as medically appropriate) or the resident's representative; g. interviews the resident's attending physician as needed to determine the resident's condition; h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; i. interviews the resident's roommate, family members, and visitors; j. interviews other residents to whom the accused employee provides care or services; k. reviews all events leading up to the alleged incident; and l. documents the investigation completely and thoroughly. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R1's admission assessment revealed that she was admitted on [DATE], with diagnosis of dementia (group of symptoms affecting memory, thinking and social abilities). Further review revealed that she has severe cognitive impairment. Review of Resident R1's fall incident report revealed that the resident had an unwitnessed fall at 6:30 p.m. on April 18, 2025, according to the witness statement from the nurse aide, Employee E6, written the next day on April 19, 2025. Her statement indicated that the resident was found face down on the floor in front of her bed, and that she went to get the charge nurse. The charge nurse, Employee E7, who wrote a progress note thirteen days later on May 1, 2025, which indicated he alerted the nurse supervisor, Employee E8, on April 18, 2025, and both nurses proceeded to assess the resident and get two nurse aides to use the mechanical lift to pick the resident off the floor and place the resident back into bed. The charge nurse's note indicated that the supervisor was to notify the responsible party and the physician. The facility did not get the statement from the nurse responsible for Resident R1 for almost two weeks. Further review of Resident R1's fall investigation revealed that the nurse supervisor on duty when Resident R1 fell wrote a note the next day on April 19, 2025, at 11:47 a.m. which indicated that after the resident was put back to bed on April 18, 2025, she notified the physician about the fall. The next progress note in Resident R1's record was from the day shift supervisor, Employee E9, written at 11:08 a.m. on April 19, 2025. The note indicated that Resident R1's daughter came to the nursing office that morning asking for her mother to be sent to the emergency room due to signs of a clinical urinary tract infection (UTI) including increased confusion and agitation. He indicated that the physician was aware and the resident was transferred to the emergency room. There was no mention of the note referring to Resident R1's fall, the bruising on her forehead or her swollen right foot. There was no documentation in Resident R1's electronic clinical record between the fall on April 18, 2025, and when the resident was sent out by Employee E9, the morning supervisor, on April 19, 2025. Employee E9 was not interviewed as part of the investigation to rule out neglect related to Resident R1's fall until April 28, 2025, or ten days after the incident. Further review of the incident report for Resident R1's fall on April 18, 2025, revealed no witness statements from the overnight nurse of nurse aide on April 18, 2025, into April 19, 2025, indicating that they checked up on Resident R1 and what her condition was and if neglect was ruled out. The overnight supervisor, Employee E11, was not interviewed until April 30, 2025, or twelve days after the incident. The was no documented statement from the nurse aide who gave morning care to Resident R1 and delivered her breakfast tray and set her up to eat that would indicate the residents condition. Interview with the Director of Nursing on June 12, 2025, at 9:05 a.m. confirmed that the policy is to get statements from all shifts, and that there were no statements obtained from the caregivers (nurse and nurse aide) on the overnight shift on April 18, 2025, into April 19, 2025. Also that the interviews and statements for some of the key staff involved were not done until ten to thirteen days after the incident, and that this investigation was not complete, thorough or timely. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.18(e)(1) Management (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(5) Nursing services

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and interviews with staff, it was determined the facility failed to ensure a resident was provided necessary care and services related to follow up care including neurological assessment after an unwitnessed fall with head injury for one of four resident records reviewed (Resident R1). Findings include: Review of facility policy, titled, Falls - Clinical Protocol, revised March 2018, revealed the nurse shall assess and document/report the following: a. Vital signs; b. Recent injury, especially fracture or head injury; c. Musculoskeletal function, observing for change in normal range of motion, weight bearing, etc.; d. Change in cognition or level of consciousness; e. Neurological status; f. Pain; Review of Resident R1's admission assessment revealed he/she was admitted on [DATE], with diagnosis of Dementia (group of symptoms affecting memory, thinking and social abilities). Review of the Brief Interview for Mental Status completed on April 14, 2025 revealed a score of 5, which indicated the resident had severe cognitive impairment. Review of Resident R1's fall incident report revealed a witness statement from the nurse aide, Employee E6, written on April 19, 2025, indicating the resident had an unwitnessed fall on April 18, 2025 at 6:30 p.m. The statement indicated the resident was found face down on the floor in front of (his/her) bed, and Employee E6 went to get the charge nurse. The charge nurse, Employee E7, who document via a nursing note thirteen days later on May 1, 2025, indicated he alerted the nurse supervisor, Employee E8, on April 18, 2025, and both nurses proceeded to assess the resident. Full body, pain, and skin assessments were performed. Patient skin is intact, no noted injuries, no c/o (complaint/of) of pain. Resident was asked how'd [resident] fall. [Resident] stated [he/she] was reaching for bed side table. The hoyer lift was used along w/ (with) two nursing assistants to help resident to bed. Review of a written statement from nurse aide, Employee E17 who was assigned to Resident R1 during the 3-11 shift on March 18, 2025 revealed that Resident R1's roommate rang the call bell and when Employee E17 responded she heard screaming coming form the room. Employee E17 observed Resident R1 lying on the floor in front of the bed face down. Employee E17 immediately went and reported it to the charge nurse who then went to the nursing supervisor to report the incident. Resident R1 was assisted of the floor. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse supervisor wrote a note the next day on April 19, 2025, at 11:47 a.m. which indicated that after the resident was put back to bed on April 18, 2025, she notified the physician about the fall. Review of nursing notes from April 18, 2025 and April 19, 2025 revealed no documented evidence of neurological assessments or assess for change in condition through the evening of April 18, 2025, overnight through the 11:00 pm.-7:00a.m. shift (April 18-19, 2025) or morning shift after the unwitnessed fall. Further review of Resident R1's clinical record revealed additional nursing note from the day shift supervisor, Employee E9 written at 11:08 a.m. on April 19, 2025. The note indicated, Resident R1's daughter came to the nursing office that morning asking for [resident] to be sent to the emergency room due to signs of a clinical urinary tract infection (UTI) including increased confusion and agitation. Employee E9 indicated that the physician was aware and order for the resident to be transferred to the emergency room. There was no documentation provided in this note in reference to the fall sustained by the resident or any bruising on the resident's forehead or right foot. Telephone interview with Resident R1's daughter and responsible party on June 5, 2025, at 11:05 a.m. revealed, when she visited resident on April 19, 2025, at 9:00 a.m. she entered the room to see resident sitting up in bed with (his/her) tray in front, crying. She said that resident's roommate had told her the resident had fallen out of bed the night before. The daughter said she observed dark colored bruising all across resident's forehead, which was worse on the right side. She went on to talk to the nurse supervisor, Employee E9, who indicated, he did not know anything about resident falling. She said that he went through the computer looking at the nursing notes and said that nothing was charted about the fall. The daughter asked the supervisor to have resident sent out to the emergency room to have him/her evaluated for the fall. She said he was hesitant to call to have resident sent out, and she said she kept asking him to come and see resident's bruising across the forehead for himself. She said the conversation included having resident reassessed for a urinary track infection (UTI) that resident had been treated for to help persuade the supervisor to send resident to the hospital. She said that the supervisor sent a nurse and a nurse aide to check resident R1's vital signs and get resident ready to transport. The daughter said that when she was helping the aide get resident dressed is when she noticed that his/her right foot was swollen and sore. The daughter said that the therapy director, Employee E10, came to see if resident was ready for therapy, and that he also checked to see if there was any documentation about the fall in the computer and could not find anything. She also said that when the ambulance attendant (EMT) came he said that they were taking resident to the local community hospital, and when the daughter questioned this, he said it is only for a routine UTI. The daughter said look at resident's forehead and foot, and then she (daughter) said the EMT said that because this is trauma, they need to take resident to a medical center. The daughter again said that she did not understand how no one questioned resident's condition since the time of the fall. She said that the person who got resident up that morning and gave resident a breakfast tray must have noticed the bruising across Resident R1's forehead, and did nothing. Interview conducted with Resident R1's physician, Employee E18 on June 12, 2025, at 9:10 a.m. revealed that the resident was sent out for a UTI, she was stable, resident sent out because the daughter had concerns related to a UTI. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the hospital records from Resident R1's April 19, 2025, admission revealed findings that include a large left frontal scalp hematoma near the vertex (highest point on the head) and oblique nondisplaced fracture (diagonal break across the bone that does not result in the bone fragments being misaligned) of the mid first proximal phalanx (toe bone closest to the leg) with surrounding soft tissue swelling. Interview with the Director of Nursing on June 4, 2025, at 3:00 p.m. confirmed there were no monitoring or neuro checks (systematic assessments used to evaluate a patient's neurological status, cranial nerve function (providing sensory, motor, and autonomic control of structures in the head, neck, and trunk), motor response (checking the patient's ability to move and respond to stimuli) and sensory function (testing the patient's ability to feel sensations) documented for Resident R1 after possible fall until resident was sent out to the emergency room. 28 Pa. Code:201.18(a)(b)(1)(3) Management. 28 Pa. Code:211.12(d)(1)(5) Nursing services.