

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395545	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/23/2025
NAME OF PROVIDER OR SUPPLIER Accela Rehab and Care Center at Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the facility's policy, clinical records, and staff interviews, it was determined that the facility failed to administer pain medication in accordance with professional standards of practice for one of one resident reviewed (Resident R1).</p> <p>Findings include:</p> <p>Review of facility policy Administering Medication Policy, revised April 2019, revealed that Medication are administered in a safe and timely manner, and as prescribed. Under #29 it further stated If a resident uses PRN (as needed) medication frequently, the attending physician and interdisciplinary care team, with support from the consultant pharmacist as needed, shall reevaluate the situation, examine the individual as needed, determine if there is a clinical reason for the frequent PRN use, and consider whether a standing dose of medicine is clinically indicated.</p> <p>A review of the resident clinical file revealed that Resident R1 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.</p> <p>Review of physician orders for Resident R1 dated May 20, 2025, revealed an order for Oxycodone (opioid pain medication) 15 milligrams give 1 tablet by mouth every 4 hours as needed for pain.</p> <p>Review of Medication Administration Record (MAR) for May 25, 2025, it revealed that Resident R1 received Oxycodone at 06:00 a.m., 10:09 a.m. 3:09 p.m. and at 9:41 p.m.</p> <p>Review of facility's investigation revealed that on May 25, 2025, Resident R1 approached a charge nurse at approximately 8-8:15 p.m. asking for PRN oxycodone which he was due.</p> <p>(continued on next page)</p>

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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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on the facility's investigation and the undated nursing statement, Employee E3 reported Resident R1 stated he wanted oxy by saying I want oxy unsure if he had a speech deficit, I asked him what he said I he made a full sentence informing me of his desire for oxycodone. I looked in the eMAR like I told him I would, and I told him if he can get it I will come back with it if not I will see him at the next med pass and give it to him if I can. I went to lunch about 8-8:14 p.m. for 30 minutes and came back around 8:45 p.m. I could not even get to the cart before the Resident R1 , came up to me using profanity and calling me names and accusing me of making him wait an hour and 45 minutes the oxy PRN, the very same oxy he was not eligible to get until about that time when I got back this guy would not let me be, so I could pass medication to everyone on my assignment. [This Resident R1] unapologetically invaded my personal space threatened me, told me I was getting fired and reported to the state. I was called a N with a very hard R and how I'm nothing and I don't deserve to be handling medication.</p> <p>Review of the statement of the supervisor on duty, Employee E4 dated May 25, 10:30 p.m. revealed The administrator called me around 9:52 p.m. to inquire why it took too long for [Resident R1] to get his pain medication. I immediately went to [Resident R1] and asked how long it had been since he asked for the pain medication. [Resident R1] stated that it's been 2 hours since he asked. I asked [Resident R1] why he didn't let me since the medication was taking too long to be administered. [Resident R1] said [the nurse, Employee E3] used racial slurs on him and that he wanted the medicine. I asked the nurse why giving the medication was taking too long. The nurse said [Resident R1] had pushed the door against her, so she went to the secure mudroom to avoid confrontation. When I was in the medroom with the nurse, trying to give him the pain medication. [Resident R1] was constantly banging on the door and shouting. I told him to calm down as we were in the process of giving him his medication. He continued knocking at the door stating that he wanted the nurse fired and that this was his sixth complaint to the state. Medication was given by the supervisor around 9:58 p.m. [The Resident R1] threw the medication cup at toward the supervisors.</p> <p>Based on the statements and a review of the Medication Administration Record (MAR) dated May 25, 2025, Resident R1 last received his medication at 3:09 p.m. He was eligible for the next dose after 7:09 p.m. Resident R1 requested Oxycodone at approximately 8:00 p.m.; however, the facility did not administer the medication until 9:58 p.m., resulting in a delay of 1 hour and 58 minutes.</p> <p>An interview with the Director of Nursing, Employee E2 and the Administrator, Employee E1 on June 23, 2025, at 1:47 p.m. confirmed that Licensed Nurse, Employee E3 failed to administer the prescribed pain medication in accordance with the physician's order.</p> <p>28 Pa Code 211.10(c) Resident care policies</p> <p>28 Pa Code 211.12(d)(3)(5) Nursing services</p>		