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	07/21/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on facility policy reviews, clinical record review, and staff interview, it was determined that the facility failed to ensure the written discharge notice included the location to which the resident is transferred or discharged for one of seven residents reviewed. (Resident R2) Findings Include:Review of Resident R2's clinical record revealed the resident received a discharge notice dated, June 19, 2025, which indicated that the facility initiated the transfer due to, the safety or health of individuals in the facility would be endangered by the patient being here. Continued review failed to reveal the location to which the resident is transferred or discharged . Interview with the facility Social Worker, Employee E3, conducted on July 21, 2025, at approximately 1:00 p.m. confirmed that the discharge notification did not include the location to which the resident is to be discharged . Continued interview revealed that, the facility was unaware of this requirement. 28 Pa. Code 201.14(a) Responsibility of licensee

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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. Based on the review of clinical records, observations, review of employee records, and staff interviews, it was determined that the facility failed to ensure that there was sufficient staff, with the appropriate competencies and skills sets which included knowledge of and appropriate training and supervision for care for residents with mental and psychosocial disorders, to provide direct services to residents to assure resident safety for four of four employee records reviewed. (Employee E4, E5, E6 and E7).Review of facility documentation dated July 5, 2025, revealed Resident R1 who was alert and oriented to self only, was noted to be off of the unit by nurse during 3pm-llpm shift. Search initiated by nurse, staff on unit notified and participated. Once it was determined Resident R1 was not on unit, nurse left unit to notify supervisor. It was at that point that nurse encountered supervisor returning Resident R1 to the unit. Resident R1 was returned back to the facility by local police. Police reported resident found around the corner at neighbor's house, resident had rang bell and neighbor contacted police when she came to door. Resident returned to facility at 6:38 p.m. Time resident was out of facility is estimated around 30 minutes. Interview with Nursing Home Administrator, Employee E1, on July 21, 2025, at 1:30 p.m. stated facility investigation revealed that the resident left through the back exit door of the facility which only could access by staff. The door was locked with a number keypad which was functioning properly after the incident. Nursing Home Administrator stated resident might have followed a staff member who opened the door with the code and walked through the hallway to the last exit door which could only open by staff without alarming. Administrator stated the door was not alarming after the elopement which indicated that a code was used to open the door. Administrator stated resident did not appear in any of the facility stair or elevator camera which confirmed that the resident used back door to exit the facility. Administrator stated all the staff worked on the unit for the shift was new agency staff (3 Nurse Aides and 1 Licensed Practical Nurses). Review of care plan for Resident R1 dated March 2, 2025, revealed that the resident was at risk for elopement related to impaired safety awareness. Interventions included staff to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Identify pattern of wandering and provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. Observation of the facility camera dated July 5, 2025, revealed that from 5:30 p.m. to 5:52 p.m., Resident R1 was wandering aimlessly in the dementia unit. All three nurse aides were sitting in the common area room in the dementia unit with limited interaction with residents. One staff was using the cell phone while sitting there. Administrator confirmed during the observation that all staff were new agency staff who did not have any prior knowledge of the resident and the unit. Administrator stated there was other facility staff working during the same time but was not assigned to the dementia unit. A request for staff training and competency records for dementia and caring of residents with behavioral health needs were requested to the Nursing Home Administrator for Employee E4, Nurse Aide, Employee E5, Nurse Aide, Employee E6, Nurse Aide, and Employee E7, Licensed Practical Nurse. Review of training records for Employees E4, E5, E6 and E7 did not reveal any evidence that the staff did not have any facility training and competency on dementia and caring residents with behavioral health needs. 28 Pa Code: 211.12 (d)(4) Nursing services 28 Pa Code: 201. 14(a) Responsibility of licensee 28 Pa Code:201.18(b)(3) Management.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on review of clinical records, facility policy, and staff interviews, it was determined that the facility failed to ensure that a resident with a diagnosis of dementia (a syndrome characterized by a progressive decline in cognitive abilities, such as memory, thinking, reasoning, and judgment, that interfere with daily functioning and social relationships), received appropriate treatment and services resulting in the resident eloping from the facility for one of seven residents reviewed. (Resident R1) Findings include: Review of undated facility policy Wandering and Elopements, revised March 2019, revealed that The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.l. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.2. If an employee observes a resident leaving the premises, he/she should:a. attempt to prevent the resident from leaving in a courteous manner.b. get help from other staff members in the immediate vicinity, if necessary; andc. instructs another staff member to inform the charge nurse or director of nursing services that a resident is attempting to leave or has left the premises. Review of clinical record revealed that the resident had diagnosis including dementia with psychotic disturbance, abnormalities of gait and mobility and anxiety. Observation conducted at the facility on July 21, 2025, revealed that Resident R1 was located in a secured (locked) unit designed to prevent the elopement of residents such as residents diagnosed with dementia and other mental health diagnosis. Review of facility documentation dated July 5, 2025, revealed Resident R1 who was alert and oriented to self only, was noted to be off of the unit by nurse during 3pm-llpm shift. Search initiated by nurse, staff on unit notified and participated. Once it was determined Resident R1 was not on unit, nurse left unit to notify supervisor. It was at that point that nurse encountered supervisor returning Resident R1 to the unit. Resident R1 was returned back to the facility by local police. Police reported resident found around the corner at neighbor's house, resident had rang bell and neighbor contacted police when she came to door. Resident returned to facility at 6:38 p.m. Time resident was out of facility is estimated around 30 minutes. Continued review of facility documentation revealed that both doors determined to be functioning. Staff did not note alarms going off. Daughter of resident stated mother has tendencies to follow people, potentially managed to leave behind staff leaving unit unnoticed. No staff interviewed noted anyone leaving behind them.Review of care plan for Resident R1 dated March 2, 2025, revealed that the resident was at risk for elopement related to impaired safety awareness. Care plan also revealed that the resident had impaired thought process related to dementia. Interventions included staff to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Identify pattern of wandering and provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. Interview with Administrator, Employee E1, on July 21, 2025, at 1:30 p.m. stated facility investigation revealed that the resident left through the back exit door of the facility which only could access by staff. The door was locked with a number keypad which was functioning properly after the incident. Administrator stated resident might have followed a staff member who opened the door with the code and walked through the hallway to the last exit door which could only open by staff without alarming. Administrator stated the door was not alarming after the elopement which indicated that a code was used to open the door. Administrator stated resident did not appear in any of the facility stair or elevator camera which confirmed that the resident used back door to exit the facility. Administrator stated all the staff worked on the unit for the shift was new agency staff (3 Nurse Aides and 1 Licensed Practical Nurses) Observation of the facility camera dated July 5, 2025, revealed that from 5:30 p.m. to 5:52 p.m, the resident was wandering aimlessly in the unit. All three nurse aides were sitting in the common area room with limited interaction with residents. One staff was using cell phone while sitting there. Administrator confirmed during the observation that all staff were new agency staff who did not have any prior knowledge of the resident and the unit. Interview with Administrator, Employee E1, on July 21, 2025, at 1:30 p.m. confirmed that Resident R1 was in a locked unit for residents with dementia and did not receive appropriate supervision and redirection according to the plan of care which led to the elopement of Resident R1. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management28 Pa. Code 201.18(e)(1) Management28 Pa. Code 211.10(d) Resident care policies28 Pa. Code 211.12(d)(1) Nursing services28 Pa. Code 211.12(d)(5) Nursing services.