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 03/10/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and facility policy review, it was determined that the facility failed to develop and revise a comprehensive, person-centered care plan to related fall risk for 1 of 3 residents reviewed (Resident R1). Findings include: Review of the facility policy titled Care Plans - Comprehensive Person-Centered Care (Revised March 2022) revealed that each resident must have an individualized care plan with measurable goals and timeframes to address physical, psychosocial, and functional needs. The policy states that assessments are ongoing and the interdisciplinary team must review and update the care plan when there is a significant change in condition, after hospitalization, when outcomes are not met, and at least quarterly with the MDS assessment. The policy also requires completion of a Significant Change in Status Assessment when a resident experiences a major decline or improvement affecting multiple areas of health status, requiring interdisciplinary review and revision of the care plan. Events such as falls and hospitalizations require reassessment and care plan updates to address changes in the resident's condition and safety needs. Review of the facility policy titled Fall and Fall Risk Management (Revised March 2024) revealed that staff must assess each resident's fall risk and implement individualized, resident-centered interventions based on identified risk factors and causes to prevent falls and minimize complications. The policy defines a fall as unintentionally coming to rest on the ground, floor, or lower level, including situations where a resident would have fallen without assistance. The policy requires staff, in collaboration with the attending physician, to develop and implement fall prevention interventions, monitor the resident's response, and modify or add interventions if falls continue. If falls recur, staff must reassess the resident, reevaluate potential causes, and implement additional or different interventions while documenting the resident's response and rationale for ongoing risks when falls cannot be prevented. Review of Resident R1's quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident R1 entered the facility on February 28, 2019 and had diagnoses including anemia (low red blood cells causing fatigue and weakness), hypertension(high blood pressure), peripheral vascular disease (reduced blood flow to the extremities), renal failure requiring dialysis (impaired kidney function requiring treatment), anxiety, depression, and schizophrenia (affecting thought processes, perception, and behavior). The MDS indicated the resident required supervision for toileting, showering, dressing, transfers, and walking. The resident's Brief Interview for Mental Status (BIMS) score was 9, indicating moderate cognitive impairment. Review of Resident R1's nursing documentation revealed that the resident experienced multiple fall incidents as follows:-1/14/2026 - Resident R1 fell from a chair in the dining room, sustaining minor bleeding to the left hand.-1/25/2026 - Resident R1 stumbled and fell to the knees. The resident suffered no injuries.-1/28/2026 - Resident R1 was hospitalized and diagnosed with a hemoglobin of 6.6 and a subdural hematoma.-2/6/2026 - Resident R1 was readmitted to the facility.-2/7/2020 - Resident sustained a witnessed fall to the knees during care. Continued review of nursing documentation revealed that the resident was transfer back to the hospital for change of mental status. Interview with nurse aide, Employee E3 on March 10, 2026, at 2:10p.m. revealed that when (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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NAME OF PROVIDER OR SUPPLIER: Accela Rehab and Care Center at Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE: 850 Papermill Road Glenside, PA 19038	

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff found the resident seated on his bed with an existing eye injury, (he/she) collapsed to his knees while attempting to stand and required staff assistance. The resident resisted help and was physically agitated. Staff reported that although the resident's bed was kept in a low position as a precaution, no additional interventions, supervision measures, or individualized care plan updates were in place to prevent similar incidents. Review of Resident R1's care plan revealed that the resident was care planned for a decline in mobility related to impairments in strength, balance, cognition, and safety awareness, with therapy services initiated in February 2026. Despite documented weakness, decreased safety awareness, and repeated falls, the care plan failed to include specific, individualized interventions to address the resident's progressive functional decline or need for increased supervision. Additionally, Resident R1 was care planned for fall risk with a history of prior falls; however, interventions such as encouraging wheelchair use, therapy referrals, and a pharmacy consult were minimal and were not revised following subsequent falls. There was no evidence that the interdisciplinary team updated the care plan to include enhanced safety measures, increased monitoring, or alternative interventions despite continued fall incidents. Interview with the Director of Nursing (DON), Employee E2 on March 10, 2026, at 2:55 p.m. confirmed that after the resident returned from the hospital on the February 6, 2026, the facility failed to implement formal neurological assessments or update the care plan to address the resident's new needs. Instead, staff relied on routine safety checks and general nursing assessments. The DON noted that discharge instructions from the hospital provided no specific guidance regarding the resident's hematoma, and staff relied solely on standard monitoring for confusion, slurred speech, weakness, or fall risk. 28 Pa Code 211.10 (d)Resident Care Policies 28 Pa. Code 211.12(d)(1)(5) Nursing Services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on clinical records review, it was determined that the facility failed to ensure that clinical records were accurate for one of three clinical records reviewed. (Resident R1) Findings include:Review of Resident R1's nursing documentation revealed that the resident experienced multiple fall incidents as follows:-1/14/2026 - Resident R1 fell from a chair in the dining room, sustaining minor bleeding to the left hand.-1/25/2026 - Resident R1 stumbled and fell to the knees. The resident suffered no injuries.-1/28/2026 - Resident R1 was hospitalized and diagnosed with a hemoglobin of 6.6 and a subdural hematoma.-2/6/2026 - Resident R1 was readmitted to the facility. Review of Resident R1's assessment completed February 6, 2026, revealed an inaccurate assessment. The nursing assessment noted that the resident was alert and oriented x 3 (people, place and situation), with normal gait and balance, no falls in the prior three months. Review of Resident R1's February 2026 medication review documentation inaccurately indicated the resident had not received psychotropic medications within the prior seven days. Review of Resident R1's February 2026 physician orders revealed that the resident was ordered the following psychotropic medications: Seroquel, Fluphenazine, Divalproex sodium, Benztropine, and Clonazepam. 28 Pa Code 211.12(d)(1) Nursing services