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	06/17/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on review of facility policy and interviews with residents and staff, it was determined that the facility did not ensure that an appropriate process was in place for distributing mail to residents within 24 hours of delivery to the facility, including on the weekends for four of eight residents reviewed (Resident R3, R4, R6, and R7). Findings include:Review of facility policy titled Resident Mail Handling Policy, most recently revise in February 2026, revealed that Incoming mail should be distributed to residents within seventy-two (72) hours of receipt by the facility.Interviews were conducted on June 17, 2026, with alert and oriented residents.An interview with resident R3 at 10:45 a.m. revealed that mail is delivered through the administrator at his discretion, but that it isn't delivered on weekends when the administrator was not in the building. She further revealed that she has been waiting on a letter which should include a payment, and that not having it yet has caused her some distress.An interview with resident R4 at 10:57 a.m. revealed that mail delivery is delayed and that I was told it's kept up front so the administrator can go through it before delivery but specified that the mail had not been opened on delivery. An interview with resident R6 at 11:10 a.m. revealed that she was expecting a letter from the social security office for a couple of months, but that it still has not been delivered to her.An interview with resident R7 at 11:19 a.m. revealed that he was also waiting for a letter from the social security office which should be here but had not yet been delivered to him by the facility.In interview with employee E1, the Nursing Home Administrator, at 2:00 p.m. on June 17, 2026, he confirmed that he had implemented a mail delivery system wherein the received mail is given to him so that he can sort it before delivery to the residents. He stated that there is typically a 24-hour turnaround for delivery, but that any mail delivered over the weekend when he is not working would be delivered to the residents the following Monday, which was outside of the required 24-hour window. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.29(a) Resident rights.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review, interviews with residents and staff, and observations on the units, it was determined that the facility did not ensure that portable air conditioning units were properly and safely installed for 13 out of 13 rooms observed (rooms 102, 104, 117, 121, 133, 138, 209, 212, 214, 221, 226, 235, 238). Findings include:Review of the installation manual for portable air conditioning unit Hisense model #AP0836DK1W revealed on page 8, Install The Portable Air Conditioner, subsection, Window Installation revealed that the user should Attach the window exhaust adapter to the outer slider (the piece with the large exhaust hole), and that the unit must be used with the included Duct Window installation kit for effective cooling. In an email sent on June 17, 2026, at 2:20 p.m., employee E1, the Nursing Home Administrator, stated that this model was in use in the facility. He also stated that the other model in use was Black and Decker, model #BPB20KWBL. No manual was provided for this model. Review of records for resident R2, revealed that his most recent BIMS assessment (Brief Interview for Mental Status- an assessment of resident cognition and orientation), was dated April 21, 2026. His score was 15 out of a possible 15, indicating that he was cognitively intact. During an interview with resident R2 on June 17, 2026, at 10:33 a.m., he stated that when the facility installed portable air conditioning units in rooms, they were not properly secured. He stated that as they did not seal the exhaust into the window, the exposed screens let heat in, making units less effective at reducing the temperature in the rooms. Observations conducted in the facility on June 17, 2026, beginning at 11:52 a.m. in the presence of employee E1 revealed rooms 102, 104, 117, 121, 133, 138, 209, 212, 214, 221, 226, 235, and 238 to have portable air conditioning units. All units were observed to be positioned near the windows, with exhaust ducting leading to the partially windows. Ducts were held in place between the windowsill and the windowpane. The ducts were not secured in the window, and the screens were exposed. During observations, employee E1 tripped over a duct, pulling it from the window. He confirmed that the reason it came free was that it was not properly secured.