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	03/06/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347 Based on review of clinical records, observation, review of facility policy and resident and staff interviews, it was determined that the facility failed to maintain resident dignity related to appropriately sized gowns and linens being available for three of 21 residents reviewed. (Resident R 77, R31, R78) Findings: Review of facility assessment last reviewed February 28, 2025 revealed that the resident's physical environment has supplies readily available to this facility including bed frames, mattresses, specialty mattresses, bariatric equipment, housekeeping equipment, as well as non-medical supplies such as bed and bath linens. Review a facility policy titled Resident Rights dated February 2021, revealed Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's rights to a dignified existence, to be treated with respect, kindness, and dignity to be free from abuse neglect misappropriation of property and exploitation. Review of facility policy titled Bariatric dated September 2024, revealed the facility is to treat each resident individually with the ultimate goal of optimizing each person's state of well being. The facility will care for its bariatric residence in a safe and dignified manner at all times. Residents will be reviewed on an individual basis with balance risks, needs and resources. Prior to admission, supplies needed such as bed frames mechanical lifts, adaptive equipment, will be attained prior to the admission to the facility. Review of Resident R77's Minimum Data Set (MDS- a federal mandated assessment tool for all residents) admission assessment dated [DATE], revealed this resident entered the facility December 21, 2024 with diagnoses including heart failure, arthritis (disease that causes pain and swelling in the joints), depression and schizophrenia (mental disorder the effects a person ability to think, feel, and behave clearly). Resident77 weight was 618 pounds with limited functional abilities for activities of daily living such as transferring, dressing, toileting which all require assistance. Resident 77 was wheelchair dependent which a BIMS (brief interview of mental status) score of 15, indicating the resident was cognitively intact. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on March 4, 2025 at 11:10 am on the first floor nursing unit hall revealed Resident R77 was witnessed being propelled in her wheelchair through the corridor by nursing aide, Employee E18. Resident R77 was seen undressed and exposed with only a top sheet covering her body minimally. Interview with Employee E18 on March 4, 2025 at 12:23p.m. revealed that she completed bathing Resident R77 and the resident did not want to put on her old clothes, therefore the employee only had a sheet available to cover the resident during transporting her back to her room. Employee E18, stated there there are no gowns available to appropiately fit this resident. Interview with Resident R 77 on March 6, 2025 at 10:55 a.m. revealed that the facility does not have enough sheets to properly fit her mattress, she must go without sheets on the bed. Review of Resident 31's Minimum Data Set (MDS a federal mandated assessment tool for all residents) quarterly assessment dated [DATE], revealed this resident was admitted into the facility October 29, 2024 with diagnoses including peripheral vascular disease, depression and asthma (chronic disease that effects the airways in the lungs). Resident 31 weighted 401 pounds. This resident was dependent for toileting hygiene requiring partial or moderate assistance for bathing, assistance for dressing, and for transfers. Residents R31's BIMS (brief interview of mental status) score was 15 indicating the resident's cognition is intact. Observation of resident in her bed on March 5, 2025, at 11:05a.m. resident was observed without any clothes, only a blanket to cover her and without any sheets, lying on the plastic mattress. Interview with Resident R31 at time of the above observation, Resident R31 stated that she was very uncomfortable, her legs were itching from the plastic. She prefers no gown because it does not fit right. Interview with Licenced nurse, Employee E10 at time of the above observation confirmed that resident was in bed without any sheets. Employee asked the resident if she was provided care that morning. Resident replied yes, the aide could not find any sheets Review Resident R78' s quarterly Minimum Data Set, dated dated dated [DATE], revealed the resident entered the facility May 21, 2024 with diagnoses including include peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow), anxiety disorder and depression. The resident weighted 353 pounds with required maximal assistance for activities of daily living such as toileting, bathing, and transferring. Resident R78's BIMS score of 15 indicating that the resident's cognition was intact . Observation of resident on March 3, 2025 at 12:12 p.m. revealed resident lying in the bed without any clothes. Interview with resident at the time of the above observation revealed that she preferred no clothes. The gowns that were given to her were too small and uncomfortable. Resident R78 was asked if the facility provided her with an appropriately fitted gown, would she wear it, Resident R 78 replied yes. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Environmental Service, Employee E5, on March 4, 2025 at 01:05 p.m. revealed that he has limited bariatric gowns, approximately one dozen. This employee stated that the bariatric population has increased and the supply order has not reflected that increase of needs. Asked why they are not on the nursing units and replied they have to ask for them. 28 Pa. Code 201.18 (b)(2)Management 28 Pa. Code 201.29 (j) Resident Rights 28 Pa. Code 211.12 (d)(1)Nursing Services

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 43923 Based on observation and an interview with staff, it was determined that the facility failed to ensure that the most recent Department of Health Survey results were in a place readily accessible to residents and visitors for two or two nursing units. (First floor, Second Floor) Findings Include: Observations conducted on March 4, 2025, at 11:33 a.m. with the Nursing Home Administrator, Employee E1 to observe where the Department of Health Survey binder was in the facility. Upon observing the front lobby facilities, it was noted that the Department of Health survey results binder was placed behind the desk in the main lobby, making it inaccessible to residents and visitors without asking. A review of the binder showed that the information was outdated, with the last survey results recorded on September 1, 2022. The second-floor binder contained results from April 17, 2023, while the dining room binder, where residents gather for meals and activities, was last updated on April 26, 2023. The Administrator confirmed that this was an area they had identified for improvement but had not yet had the time to update the Department of Health Survey binders. 28 Pa. Code 201.14(a) Responsibility of licensee

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 48347 Based on review of facility policy, observation, interview with staff, it was determined the facility failed to ensure that resident's confidentiality was protected related to staff using personal device to access resident protective health information (PHI) for one of two nursing units (First floor nursing unit). Findings include: Review of facility policy titled Protected Health Information(PHI) safeguarding Electronic dated February 2014, revealed Electronic protected health information (e-PHI) is safeguarded by administrative, technical and physical means to prevent unauthorized access to protected health information. All business associates are required to comply with security standards established by our business associate agreement relative to e-PHILA cultural of society awareness and protection of PHI is reinforced among employees and staff through initial training, periodic training and information system security. Review of facility policy titled Protective Health Information (PHI) Common Management and Protection of dated April 2014 revealed the protected health information (PHI) shall not be used or disclosed except as permitted by current federal and state laws. It is the responsibility of all personnel who have access to resident and facility information to ensure that such information is managed and protected to prevent unauthorized release or disclosure. When using or disclosing PHI, or when requesting PHI from another entity, reasonable efforts must be made to limit the PHI used or disclosed to the minimum necessary to accomplish the purpose of the use or disclosure of such information. Review of facility Handbook (a document given to all employees) dated September 3rd 2024 revealed that the purpose of the handbook is to provide a general understanding of the personnel policies and rules of the center. The handbook included an outline of Use of Electronic Devices which provides facility regulations that are to ensure resident, family member, visitor and employee privacy and the protection of confidential information, the use of personal handheld electronic devices while on duty without advance approval by the Administrator is prohibited. Personal handheld electronic devices include, but are not limited to, cellular telephones, smart phones, tablets, pagers, cameras, personal music devices (iPods and other MP3 players) and other similar technology. During breaks, electronic devices may be used in non-resident care areas. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Review of US Department Health and Human Services policy Titled Health Information Privacy last reviewed March 2025 revealed The Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services (HHS) issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).1 The Privacy Rule standards address the use and disclosure of individuals' health information-called protected health information by organizations subject to the Privacy Rule - called covered entities, as well as standards for individuals' privacy rights to understand and control how their health information is used. A central aspect of the Privacy Rule is the principle of minimum necessary use and disclosure. A covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request.50 A covered entity must develop and implement policies and procedures to reasonably limit uses and disclosures to the minimum necessary. A covered entity must maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent intentional or unintentional use or disclosure of protected health information in violation of the Privacy Rule and to limit its incidental use and disclosure pursuant to otherwise permitted or required use or disclosure.70 For example, such safeguards might include shredding documents containing protected health information before discarding them, securing medical records with lock and key or pass code, and limiting access to keys or pass codes. Observation on March 3, 2025, at 09:28 a.m. of Licensed nurse, Employee E17 on the first-floor nursing unit during medication pass, this employee was seen using her personal IPAD (A portable handheld device that communicates with personal phone and watch) this is a personal device without technical safeguards. Interview with Licensed nurse Employee E17 at time of above observation, employee was question what the computer she was working was, this employee responded that it was her personal IPAD which was easier tiowork with between residents. Employee E17 stated that she just was able to log into PCC (computer program with all resident personal information) from the website. Interview with Human Resources Director, Employee E21 on March 6, 2025, at 10:55a.m. revealed that all employees are provided with employee handbooks that contain all facility rules including personal phone/ device use while on the nursing units. Interview with Assistant Nursing Home Administrator, Employee E27 on Mach 6, 2015 at 09:40 a.m. revealed that the facility's computer system that is used for all resident personal health information has several layers of safeguarding to protect and secure all the information. This is provided to shield any information that could be subject to any data breech or online cyber-attack. More protection then a personal computer . 28 Pa. Code 201.29(i)Resident Rights 28 Pa. Code 211.12(d)(3) Nursing Services

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 43923 Based on a resident group interview, resident interview, review of facility policy and procedures, and staff interview, it was determined that the facility failed to ensure that the grievance forms were available and accessible to residents on the nursing units for 19 of 21 residents (Residents R14, R32, R75, R51, R79, R48, R50, R102, R63, R10, R57, R87, R90, R2, R12, R64, R18, R27, R101) Findings include: A review of facility policy titled Grievances/Complaints, Filing revised April 2017 stated residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances. It further stated under bulletin #5 Grievances and/or complaints may be submitted orally or in writing and may be filed anonymously. During a resident council meeting on March 4, 2025, at 10:30 a.m. with 19 residents, (Residents R14, R32, R75, R51, R79, R48, R50, R102, R63, R10, R57, R87, R90, R2, R12, R64, R18, R27, R101) who were identified as being alert and oriented, revealed that the residents were unaware of where the grievance forms were located. The residents were unaware of any location of grievance/concern submission boxes to submit an anonymous grievance. On March 4, 2025, at 11:33 a.m., a facility tour was conducted with the Nursing Home Administrator, Employee E1. During the tour, it was confirmed that grievance forms were not available on the first and second-floor main and pavilion nursing units. Nurses at the nursing stations indicated that grievance forms were typically kept in the filing cabinet behind the nursing station. However, when asked to locate a copy, no grievance forms were found, and they were not accessible to residents. 28 Pa. Code 201.14(a)Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a)Resident rights

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 06525 Based on observation and staff interview, it was determined that the facility failed to ensure that residents were free of neglect related to the provision of incontinence care for one of 21 residents reviewed. (Resident R31) Findings include: Observation on March 3, 2025, at 10:35 a.m. revealed nursing aide, Employee E15 completing routine care of Resident R31 in the resident's bed. This observation revealed that the resident was lying in saturated linens. All bed linens were soaked trough with urine and needed to be changed. Interview with Resident R31 at time of the observation revealed, the overnight aides never provide care, and this resident was left is urine-soaked briefs. Interview with nursing aide, Employee E 15 at time of above observation revealed that she was completing her morning tasks and found the resident was lying in urine-soaked lines from the previous evening. Employee E15 stated that the overnight aides are supposed to provide care through the night and in the morning before the end of shift. Interview with the Director of Nursing Employee E2, in resident 31's room on March 3, 2025 at 10:45 a.m. confirmed that resident had not been attended to through the evening and he was unaware of this until it was reported at that time. 28 Pa Code 211.10(d) Nursing care policies 28 Pa Code 211.12(d)(1) Nursing services

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06525 Based on review of clinical records, interview with staff and review of facility policy, it was revealed that the facility did not ensure revision were made to the PASRR (Pre-Admission Screening and Resident Review) application to include mental health diagnoses for 3 out of 21 residents reviewed. (Resident R42 R37) Findings include: Review of the facility policy titled Admission Criteria policy last revised March 2019 revealed under bulletin 9 All new admissions and readmissions are screened for mental disorders (MD), intellectual disability (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASSARR). The facility a Level 1 PASARR screen for all potential admissions, regardless of payer sources, to determine if the individual meets the criteria for a MD, ID, or RD. Review of Resident R42's PASRR completed on October 15, 2019, indicated that Resident R62 did not have a mental health condition or suspected mental health condition. Review of R42's clinical record revealed admitted [DATE]. Clinical record review for Resident R42 revealed that the resident obtained a medical diagnosis post traumatic stress disorder as of June 12, 2023. Interview with the facility Social Worker, Employee E20 on March 5, 2025, at 10:09 a.m., confirmed that the PASSR forms for Residents: R42, had no documentation of the current mental health condition. Clinical record review for Resident R37 revealed that this resident had diagnoses that included major depressive disorder, post traumatic stress disorder and anxiety disorder. This resident also had a history of substance abuse disorder. The PASRR (Pennsylvania preadmission screening) resident review form dated June 20, 2019 indicated that this resident had a positive screen for serious mental illness; however there was no documentation to indicate that this resident was referred to the State Department of Human Services office of mental health and substance abuse services for a PASRR level II review to determination if Resident R37 was eligible for mental health services while residing in the nursing facility. Interview with the Social Worker, Employee E20, at 10:20 a.m., on March 5, 2025 confirmed that there was no documentation to indicate that Resident R37 was afforded screening with the PASRR level II process to determine eligibility for mental health services while residing in the nursing home. 28 PA Code 211.10 (c) Resident Care Policies 28 PA Code 211.5(f)(viii) Medical records

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39343 Based on review of facility policy, review of clinical records, observations, and staff interviews, it was determined that the facility failed to develop a comprehensive person-centered care plan for two of 21 Residents reviewed (R1, R84) . Findings include: Review of Resident R1's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included Cerebral Palsy (a group of movement disorders that affect a person's ability to control their muscles, balance, and posture. It is caused by damage to the brain during or before birth or in the early years of life), Acute Respiratory Failure With Hypoxia (a condition where the lungs cannot effectively exchange oxygen and carbon dioxide, leading to a buildup of carbon dioxide and a deficiency of oxygen in the blood. Hypoxia specifically refers to a state where the body or a specific tissue does not have enough oxygen), and Chronic Obstructive Pulmonary Disease (a group of lung diseases that cause ongoing breathing problems. It is characterized by airflow obstruction and inflammation of the airways, leading to difficulty breathing, especially during physical activity). Review of physician order for Resident R1, dated January 1, 2025, indicated an order to administer Oxygen at 2 Liters/minute, via nasal canula, to keep Oxygen Saturation above 93%, every shift for Shortness of Breath. Review of the care plan for Resident R1, on March 4, 2025, at 10:01 a.m., revealed that there were no focus, interventions, and outcomes (goals) care- planned for oxygen administration. On March 6, 2025, at 10:26 a.m., interview with the Director of ursing (DON) confirmed the above findings. Review of Resident R84's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included Laceration Without Foreign Body on Right Foot (a wound that results from tearing or splitting of the skin or underlying tissue), Peripheral Vascular Disease (a condition that affects the blood vessels outside the heart and brain. It occurs when the arteries or veins become narrowed or blocked, reducing blood flow to the extremities, typically the legs and arms), and Non-pressure Chronic Ulcer of left Heel and Midfoot. Review of updated physician order for Resident R84, dated March 4, 2025, indicated an order to Cleanse right dorsal foot with NSS, apply 1/4 Dakin (wet to moist, cut to wound size), followed by an ABD pad and Kling wrap, every dayshift for Wound care. Review of the care plan for Resident R84, on March 6, 2025, at 10:19 a.m., revealed that there were no focus, interventions, and outcomes (goals) care- planned for wound treatment dministration on right dorsal foot. On March 6, 2025, at 10:26 a.m., interview with the DON confirmed the above findings. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa Code 211.10 (c)(d) Resident care policies 28 Pa Code 211.12(d)(1)(3)(5) Nursing services

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06525 Based on review of facility policy, review of clinical records, and staff and resident interviews, it was determined that the facility failed to provide necessary services to maintain adequate grooming for dependent residents for two of 21 residents reviewed (Resident R70, and R95) Findings include: A review of the Activities of Daily Living (ADL), Supporting) policy last updated May, 2018, indicated Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Review of admission record indicated Resident R70 was admitted to the facility on [DATE], with a diagnosis of cerebral infarction due to embolism of left middle cerebral artery (stroke), open wound, right knee, muscle weakness, injury of right lower leg, and need for assistance with personal care. Review of Resident R70's Admission Minimum Data Set (MDS - a periodic assessment of care needs) dated February 3, 2025 revealed the resident required assistance with personal hygiene with partial/moderate assistance. A review of Resident R70 s care plan dated November 08, 2024, revealed the resident is totally dependent on 1 staff to provide a bath/shower, repositioning and turning in bed, for dressing and for eating. Observations on March 3, 2025, at 10:28 a.m. revealed Resident R70 had long nails on right hand and Resident R70 wanted the nails to be cut. Right hand was contracted. When asked when the last time was, he had a shower, Resident R70 reported a month ago, I get bed baths, and it would be nice to get a shower. On March 3, 2025, at 10:37 a.m. a license nurse, Employee E3 confirmed the observation of long nails on right hand. It was revealed that Resident R70 receives showers on Wednesdays and Saturdays. On March 5, 2025, at 11:45 p.m. observation was made, and the nails were still long. License nurse, Employee E 25 confirmed the observation that all 5 fingernails had long nails on his right hand which was contracted. Observations of Resident R95 at 12:00 p.m., on March 3, 2025 and 11:30 a.m., on March 4, 2025 revealed that this resident was in laying upright in bed. The resident was observed with hair disheveled, uncombed and greasy. The resident was also observed with untrimmed, jagged and dirty fingernails. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accela Rehab and Care Center at Springfield	850 Papermill Road Glenside, PA 19038

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clinical record review for Resident R95 revealed an admission comprehensive assessment MDS (an assessment of care needs) dated January 23, 2025. The assessment indicated that this resident was admitted to the facility on [DATE]. The resident was assessed as being cognitively intact. The resident was identified with functional limitation of the upper extremities. The assessment also said that Resident R95 was dependent on staff assistance to shower and bathe. Resident R95 required substantial/maximal assistance of one person to complete personal hygiene (combing hair, grooming). The assessment indicated that Resident R95 was dependent on staff to perform transfers bed to chair/chair to bed. Interview with Resident R95 at 11:45 a.m., revealed that the staff do not get her out of bed. The resident reported that she did not have a wheel chair to be transferred into. The resident said that she had not been taken to the shower. Resident R95 reported that she did receive a bed bath once a week. Interview with the licensed nurse, Employee R12, at 10:00 a.m., on February 3, 2025 revealed that this nurse was most familiar with the care needs of Resident R95. The nursing staff member reported that Resident R95 had not requested to get out of bed. The licensed nurse, Employee E12 reported that she planned to have Resident R95 added to the hair dresser list and services. The licensed nurse also said that plans were to have the activities department staff soak, trim, file and paint Resident R95's fingernails. Observations of the feet and wound care for Resident R95 revealed that in addition to the resident's right heel and left heel wounds it was obvious that the resident's lower extremities were extremely dry with peeling skin. 28 Pa. Code 211.12 (d)(1) (5) Nursing Services

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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** 43923 Based on review of facility policy, review of residents clinical records, observation and interview with staff, it was determined that facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice related to physician orders of medication administration and weekly weights for two of 21 residents observed. (Resident 45 and Resident 100) Findings include: Resident R45 was admitted to the facility on [DATE], with the following diagnoses of atherosclerotic heart disease of native coronary artery with unstable angina pectoris (limit or blocks blood flow to various parts of your body, including your heart and brain), dementia, and epilepsy. Review of Resident R49's clinical record revealed a physician order for the Resident R45 to obtain weekly weights x 4 every day shift every Tuesday on January 28, 2025. A review of clinical record further revealed that weekly weights were taken on January 28, 2025, February 1, 4,11, 2025. There were no weekly weights for the week of February 18, and 25, 2025. An interview with the unit manager, Employee E4 on March 5, 2025, at 11:25 a.m. confirmed that weekly weights were not obtained as ordered by the physician. An interview with the dietician, Employee E 26 confirmed that weekly weights were not obtained and there was 4.01% of weight loss from January 28, 2025 to March 4, 2025. Review of facility policy title Administering Medications revised April 2019 revealed Medications are administered in accordance with prescriber orders. The individual administering medication checks the label three times to verify right resident, right medication, right dosage, right time and right method root of administration before giving the medication. As required or indicated for a medication the individual administering the medication records in the residence medical record daytime medication was administered, dosage, root of administration. Review of Resident R100's admission Minimum Data Set (MDS- federal mandated tool for assessments of all residents) dated December 12, 2024, revealed that Resident R100 was admitted into the facility on [DATE], with diagnoses' including aphasia (disorder that effects a person's ability to communicate), cerebrovascular accident(stroke- loss of blood flow to the brain), hemiplegia(paralysis or weakness on one side of the body), malnutrition(nutritional deficiency), anxiety and depression. Resident R100 was 106 ponds and requires nutrition through a feeding tube. This resident was assessed of being absent of speech and spoken words. She may respond adequately to simple direct communication and only sometimes understands. A brief interview for mental status (BIMS-cognition assessment) was unable to be conducted for Resident R100. (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 Resident 100's clinical physician orders revealed and order for Aspirin 81 oral tablet to be given via g-tube one time a day dated December 6, 2024. Further review of Resident R100' s physician orders revealed Magnesium Oxide 400 Oral Packet (Magnesium Oxide (Mg Supplement) to be given one packet via G-Tube one time a day dated December 19, 2024. Observation of medication pass one first floor nursing unit cart middle and low on March 4, 2025 at 09:32 a. m. with Licensed nurse, Employee E16 revealed this employee administering the medications; Magnesium Oxide 400, Aspirin 81 Oral Tablet, Buspirone HCl Oral Tablet 15 MG (milligrams) and Buprenorphine HCl-Naloxone HCl Sublingual Film 8-2 MG all given to Resident R100 orally. Interview with Employee E16 on March 4, 2025, at 09:40 confirmed she administered the medications to Resident R 100 orally, the employee stated that the resident no longer uses the g-tube. Interview with Employee E2, Director of Nursing revealed that the resident is currently on a trial for oral ingestion, she is now taking her medications orally and confirmed that the physican orders needed to be updated to reflect the resident current needs. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1) Nursing services

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06525 Based on observations of care and services, clinical record reviews, interviews with staff and reviews of policies and procedures, it was determined that the facility failed to assess and monitor one of two residents reviewed for sensory and communication needs, to ensure that treatment and assistive devices to maintain hearing abilities provided to each resident. (Resident R95) Findings include: A review of the facility policy titled sensory impairments dated March, 2018 revealed that it was the responsibility of the staff and physician to identify residents with hearing impairment. The policy indicated that the physician was responsible for ordering consultation with an audiologist to define causes and treatment options to address complications of the sensory impairment. Clinical record review revealed an admission comprehensive assessment dated [DATE] that indicated Resident R95 was cognitively intact. Observations of Resident R95 throughout all days of the survey (March 3, 4, 5, and 6, 2025) revealed that this resident had moderate difficulty with hearing. The resident was observed alone in the bedroom with the television volume turned up loudly. Conversations with Resident R95 revealed that words had to be spoken with an increased volume and distinctly for the resident to comprehend the question. Interview with Resident R95 revealed that it was the resident's preference to have the television volume turned up so that she could hear and understand it. Clinical record review revealed a nursing admission assessment dated [DATE] that indicated Resident R95 was identified as having hearing deficit. Despite this admission assessment for Resident R95 there was no evaluation by a professional specializing in the provision of hearing assitive devices. Interview with licensed nursing staff Employee E12, at 10:30 a.m., on March 3, 2025 confirmed that Resident R95 had moderate hearing impairment. The nurse described getting close to the resident and speaking with her in a higher than normal tone of voice so that the resident could understand the conversation. 28 PA. Code 211.10(c) Resident care policies 28 PA. Code 211.12(d)(1)(3) Nursing services

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 39343 Based on review of clinical record review, and staff interview, it was determined that the facility failed to implement treatment and services for incontinence management for one of 21 residents reviewed.(Resident R1). Findings include: Review of physician order for Resident R1, dated January 29, 2025, indicated an order for Supra Pubic Catheter with size 16FR (french)/10 CC Balloon. On March 4, 2025, at 9:14 a.m., it was observed that Resident R1 had a Supra Pubic Catheter of 22 FR/10 CC Balloon, instead of 16FR/10 CC Balloon. At the time of the finding, confirmed the same with a Licensed Nurse, Employee E7. 28 Pa Code 211.12(d)(1) Nursing services 28 Pa Code 211.12(d)(5) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39343 Based on observation, clinical record review, review of facility policy and staff interview, it was determined that the facility failed to provide appropriate respiratory care and services for one of 21 residents reviewed (R1). Findings include: Review of Resident R1's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included Cerebral Palsy (a group of movement disorders that affect a person's ability to control their muscles, balance, and posture. It is caused by damage to the brain during or before birth or in the early years of life), Acute Respiratory Failure With Hypoxia (a condition where the lungs cannot effectively exchange oxygen and carbon dioxide, leading to a buildup of carbon dioxide and a deficiency of oxygen in the blood. Hypoxia specifically refers to a state where the body or a specific tissue does not have enough oxygen), and Chronic Obstructive Pulmonary Disease (a group of lung diseases that cause ongoing breathing problems. It is characterized by airflow obstruction and inflammation of the airways, leading to difficulty breathing, especially during physical activity). Review of clinical record indicated that Resident R1 was ordered, dated January 30, 2025, with Oxygen at 2 Liters/Min, as needed, via Nasal Cannula, to keep Oxygen Saturation above 93%, every shift, for Shortness of Breath. On March 4, 2025, at 9:12 a. m., observed that Resident R1 was administered with Oxygen at 3 Liters/Min, via Nasal Canula., and not 2 Liters/Min, as ordered by the physician; and at the time of the finding the same was confirmed with a Licensed Nurse, Employee E7. 28 Pa Code 211.12(d)(5) Nursing services

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F 0742 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 mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. 06525 Based on clinical record reviews, interviews with staff and residents and reviews of policies and procedures, it was determined that the facility failed to ensure that treatment and services were attain for two of eleven resident reviewed related to mood, behavior and the use of psychotropic medications. (Residents R37 and R48) Findings include: A review of the facility's policies titled behavioral health service and behavioral assessment, intervention and monitoring dated February and March 2019, revealed that it was the facility's responsibility to provide each resident with behavioral health services as needed to attain or maintain their highest practicable physical, mental and psychosocial well-being. The policies indicated that the behavioral health services were to be provided by staff who were qualified and competent in behavioral health and trauma informed care. The policies said that the interdisciplinary team would evaluate the new or changing behavior to identify underlying causes and address the factors that are causing physical, emotional or functional impairments for each resident. Clinical record review revealed that Resident R37 had diagnoses of PTSD (post traumatic stress disorder), Major depressive disorder, anxiety disorder and history of alcohol and cocaine abuse. Clinical record review for Resident R37 revealed a quarterly comprehensive assessment that indicated this resident was cognitively intact. Clinical record review for Resident R37 revealed that he had not had an evaluation by a psychiatrist over the past six months. The resident had been prescribed escitalopram on August 20 2023 for anxiety disorder, trazodone HCL on August 19, 2023 and mirtazapine on October 15, 2024 for major depressive disorder. Interview with the social worker, Employee E20 at 9:00 a.m., on March 6, 2025 confirmed that Resident R37 had not received psychiatrist evaluation of his psychosocial or behavioral needs over the past six months. The social worker reported that Resident R37 had reported having trouble sleeping, anxiety, nightmares, flashbacks of men he lost and violence he witnessed. The social worker said that the resident would like to resume psychological services. Clinical record review for Resident R37 revealed that it was his desire to be transferred to another nursing facility since June 3, 2024. There was no documentation to indicate that plans were underway for this request from Resident R37. Clinical record review revealed that Resident R37 revealed that on January 29, 2025 the resident was found smoking cigarettes inside his bedroom. It was documented that the family visiting the resident had provided that smoking material and cigarettes for him. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident R37 at 11:00 a.m., on March 6, 2025 revealed that this resident wanted to smoke cigarettes occasionally. The resident reported wanting to transfer to another facility, since he was a veteran of war in Vietnam; so that he could smoke cigarettes and be in the company of his comrades. Clinical record review for Resident R48 revealed a quarterly assessment MDS (an assessment of care needs) dated December 4, 2024 that indicated this resident was cognitively intact. The MDS also indicated that the resident's mood and behavior was feeling down, depressed and hopeless. The resident felt tired having little energy. The assessment indicated that Resident R48 used a manual wheel chair for locomotion and was prescribed antianxiety and antidepressant medications. Clinical record review for Resident R48 revealed that this resident had diagnoses that included schizophrenia, bipolar disorder, depression and anxiety disorder. Clinical record review and care plan review revealed that Resident R48 had a positive PASRR II level evaluation on March 4, 2020. Resident R48 was eligible for mental health services that include such services: preparation of systematic plans which are designed to facilitate appropriate behavior, drug therapy and monitoring for effectiveness and side effects, structured social activities, the teaching of daily living skills to enhance self-determination and independence, individual, group, family and personal support networks and formal behavioral modification programs. Clinical record and care plan review revealed that the social worker made a referral for the mental health services on September 30, 2024 to meet the behavioral needs of Resident R48. Interview with the facility's social worker, Employee E20, at 11:15 a.m., on March 6, 2025 revealed that Resident R48 had not been receiving any behavioral health programs since September 30, 2024; because the specialist or qualified personnel to render the care was not visiting the facility or the resident with any form of communication (electronic). Observations of Resident R48 throughout the days of the survey (March 3, 4, 5, 6, 2025) revealed that this resident was not engaging in social activities programs at the facility. Resident R48 was observed sitting outside his room in his wheel chair making aggressive and derogatory comments to staff, visitors and other residents. 28 PA. Code 211.10(a)(b)(c)(d) Resident care policies 28 PA. Code 211.12(c)(d)(1)(2)(3) Nursing services 28 PA. Code 211.5(f)(i)(ii)(iii)(vii)(viii)(ix) Medical records

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347 Based on review of facility policy, review of clinical records, observation, and interviews with staff it was determined that the facility did not ensure that insulin was provided timely to a resident as needed, and did not ensure accurate narcotic reconciliation was completed for one of three residents reviewed. (Resident R 37) Findings include: Review all facility policy Administering Medications dated April 2019 revealed only persons license or permitted by the state to prepare administer and document the administration of medications may do so. Director of nursing services supervises and directs all personnel who administer medications and have related functions. Insulin pens are clearly labeled with the resident's name or other identifying information prior to administrating insulin with an insulin pen the nurse verifies the correct pen is used for the resident. A drug that is withheld ,refused or given at a time other than the scheduled time the individual administrating the medication shall initial encircle the MAR space provided. Review of facility policy titled Storage of Medications dated November 2020, revealed drugs and biological use in the facility are stored in compartments under proper temperature, light, and humidity, only persons authorized to prepare administration of Medications have access to medications, and the nursing staff is responsible for maintaining medication storage and preparation area in a clean safe and sanitary manner. Review of resident R3.'s quarterly minimum data set (MDS- a federal mandated assessment tool for all residents) dated January 12, 2025, revealed Rresident R37 was admitted into the facility on [DATE] with diagnoses including renal insufficiency(kidney failure), viral hepatitis(liver infection) and diabetes(a chronic disease characterized by high glucose levels in the blood, controlling the body main source of energy , which occurs when the pancreas does not produce enough insulin or the body cannot effectively use insulin). Review of resident R37's clinical record physician orders revealed an order for Humalog solution 100 unit/ml (insulin Lispro), inject 3 unit subcutaneously with meals for diabetes dated May 24, 2024. Observation of med pass with licensed nurse, Employee E17 on March 4, 2025, at 09:28 a.m.(after breakfast), first floor nursing unit high cart, this employee was seen preparing medication for Resident R37. Resident's blood sugar was noted as 195, requiring 3 units of insulin. Interview with Employee E 17 at time of above observation revealed that the medication cart first floor high cart did not contain Resident R 37 insulin. Employee E17 stated that when the medication is unavailable, she will need to notify the unit manager. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued interview after Licensed nurse, Employee E 17 returned to the cart from reporting Resident R37 missing insulin, this employee confirmed that she notified the unit manager and was informed that the medication will be ordered. When questioned of timing for this medication delivery, Employee E 17 stated sometime today further delaying Resident R 37's ordered insulin to be given with meals. Interview with Employee E2 Director of Nursing on March 4, 2025, at 12:05 p.m. revealed that the insulin was in storage and resident had received it, Employee E17 was not informed that there was more insulin in storage. Employee E2 confirmed that miscommunication delayed the resident his medication. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12 (d)(3) Nursing Services

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 39343 Based on observations, review of clinical records, and interviews with facility staff, it was determined that the facility failed to ensure that it was free of medication error rate of five percent or greater for one of four residents observed during medication administration (Residents R1, R68, R37 and R100). Findings include: On March 4, 2025, at 9:02 a.m., observed that Employee E7, a Licensed Nurse, administered to Resident R1, the medicine, Fluticasone Propionate HFA Inhalation Aerosol 110 MCG/ACT, two puffs to inhale orally, and it was noticed that R1 did not rinse his mouth after inhaling Fluticasone Propionate HFA Inhalation Aerosol 110 MCG/ACT. Review of physician order for Resident R1, revealed an order, dated January 29, 2025, to administer Fluticasone Propionate HFA Inhalation Aerosol 110 MCG/ACT, inhale one puff orally every 12 hours for Allergies, and rinse mouth with water, after use to reduce aftertaste. The Licensed Nurse, E7, did not follow the physician order to administer Fluticasone Propionate HFA Inhalation Aerosol 110 MCG/ACT, one puff inhale orally for Allergies; and rinse mouth of R1 with water after use to reduce aftertaste; the Resident R1 inhaled Fluticasone Propionate HFA Inhalation Aerosol 110 MCG/ACT, two puffs. Review of literature revealed that inhaled corticosteroids like Fluticasone can sometimes lead to a fungal infection in the mouth and throat, known as oral thrush or oropharyngeal candidiasis. Rinsing mouth with water after each dose helps remove any remaining medication from the mouth and throat, reducing the risk of this infection. At the time of the finding, during an interview with E7, confirmed the above findings. On March 4, 2025, at 9:23 a.m., observed that Employee E28, a Licensed Nurse, administered to Resident R68, the medicine, Advair Diskus Inhalation Aerosol Powder Breath Activated 250-50 MCG/ACT (Fluticasone-Salmeterol), one puff to inhale orally. But R68 did not rinse mouth after inhaling the Advair Diskus Inhalation. Review of physician order for Resident R68, revealed an order, dated December 6, 2024, to administer Advair Diskus Inhalation Aerosol Powder Breath Activated 250-50 MCG/ACT (Fluticasone-Salmeterol), one puff, inhale orally, for Shortness of Breath, and rinse mouth after each use. Review of literature revealed that Advair Diskus can cause serious side effects, including fungal infection in the mouth or throat (thrush);and rinsing the mouth with water without swallowing after using Advair Diskus help to reduce the chance of getting thrush. At the time of the finding, during an interview with E28, confirmed the above findings. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of med pass with Licensed nurse, Employee E17 on March 4, 2025, at 09:28 a.m.(after breakfast), first floor nursing unit high cart, this employee was seen preparing medication for Resident R37. Resident's blood sugar was noted as 195, requiring 3 units of insulin. Review of Resident R37's clinical record physician orders revealed an order for Humalog solution 100 unit/ml (insulin Lispro), inject 3 unit subcutaneously with meals for diabetes dated May 24, 2024. Interview with Employee E17 at time of above observation revealed that the medication cart first floor high cart did not contain Resident R37 insulin. Employee E17 stated that when the medication is unavailable, she will need to notify the unit manager. Observation of medication pass one first floor nursing unit cart middle and low cart on March 4,2025 at 09:32 a.m. with Licensed nurse, Employee E16 revealed this employee administering the medications; Magnesium Oxide 400, Aspirin 81 Oral Tablet, buspirone HCl Oral Tablet 15 MG and Buprenorphine HCl-Naloxone HCl Sublingual Film 8-2 MG all given to Resident R100 orally. Review of Resident 100's clinical record physician orders revealed and order for Aspirin 81 oral tablet to be given via g-tube one time a day dated December 6, 2024. Further review of resident R100' s physician orders revealed Magnesium Oxide 400 Oral Packet (Magnesium Oxide (Mg Supplement) to be given one packet via G-Tube one time a day dated December 19, 2024. Interview with Employee E16 on March 4, 2025, at 09:40 confirmed she administered the medications to Resident R100 orally, the employee stated that the resident no longer uses the g-tube. Interview with Employee E2 Director of Nursing revealed that the resident is currently on a trial for oral ingestion, she is now taking her medications orally and confirmed that the orders needed to be updated to reflect the resident current needs. The facility incurred a medication error rate of 14.81%. 28 Pa. Code 211.10(c) Resident care polices Pa Code 211.12(d)(1) Nursing Services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39343 Based on observation and staff interview, it was determined that the facility failed to ensure all drugs and biologicals used in the facility were labeled in accordance with professional standards, and to discard expired medications in accordance with professional standards, for one of three medication carts observed and reviewed (Medication cart of Second Floor, Front Hall). Findings include: Observation of the Medication Cart at the Second Floor, Front Hall, on March 6, 2025, at 10:57 a.m., revealed; an opened one Vial of Humalog Insulin Lispro, Injection, 100 Units per ML, with expiration date as September 30, 2027, which was opened, but with no opened date marked; and an opened one Vial of Insulin Aspart, Injection,100 Units per ML, with expiration date as April 30, 2027, which was opened, but with no opened date marked. Interview with a Licensed Nurse, Employee E17, at the time of the finding, confirmed that the insulin vials should have been discarded. 28 Pa Code 211.9(g)(h) Pharmacy services 28 Pa Code 211.12(c) Nursing services

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	395545	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accela Rehab and Care Center at Springfield	850 Papermill Road Glenside, PA 19038

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06525 Based on clinical record review, pertinent dental documents, interviews with staff and reviews of policies and procedures, it was determined that the the facility failed to ensure that routine dental services were provided promptly to one of four residents reviewed for dental and nutritonal care. (Resident R38) Findings include: A review of the facility's policy titled dental examination, dated December, 2013 revealed that it was the facility's responsibility to ensure that each resident would be examined and assessed by a dentist. The policy also indicated that each resident would be given dental services as needed and any resident needing dental services will be promply assessed by a dentist. Clinical record review for Resident R38 revealed a quarterly assessment MDS (an assessment of care needs) dated January 7, 2025 that indicated that this resident was admitted to the facility on [DATE]. The assessment also indicated that this resident was cognitively intact. Clinical record documentation for Resident R38 revealed that on January 16, 2025, after Resident R38 complained of needed to see a dentist for a broken tooth, the nursing staff informed the dentist and requested that Resident R38's broken tooth be examined and addressed. The nursing staff also requested on behalf of Resident R38 that he wanted his teeth cleaned. The consulting dental services responded to the nurses request for Resident R38 to be seen and examined by the dental practice on January 17, 2025. The consulting dental practice indicated that Resident R38 was identified as requiring extractions and fillings in August, 2024. The dental practice indicated that they were able to schedule the appointment on January 17, 2025. Interview with the Director of Nursing, Employee E2, at 2:30 p.m., on March 6, 2025 confirmed that Resident R38 had not received dental care, since January 16, 2025. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 43923 Based on observations, interviews with staff, and review of facility policy, it was determined that the facility failed to ensure safe and sanitary storage and handling of personal food products brought in from outside sources for three of 21 residents. (R42, R80, R64). Findings Include: Review of Facility Policy: Foods Brought by Family/Visitors revised March 2021 states Food brought to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and homelike environment with the nutritional and safely needs or residents. Family members and visitors are requested to inform nursing staff or their desire to bring foods into the facility. Nursing staff will provide family/visitor who wish to bring foods to the facility with a copy of this policy. It further explains under bulletin 7 Food brought by family/visitors that is left with the resident to consume later will be labeled and stored in a manner that is a clearly distinguishable from facility-prepared food On March 3, 2025, at 11:16 a.m. observation revealed Resident R42 had two Ziplock bags of different bread not labeled with receipt nor expiration date. Soy sauce, blubbery jam, pancake syrup, that were opened but not stored nor refrigerated appropriately. A license nurse, Employee E3 confirmed these observations during tour of the room. On March 3, 2025, at 11:52 a.m. observation revealed Resident R80 had standing on the floor by his shoes, two containers of mayonnaise opened, a large 32 oz coffee creamer opened, 3 milk containers. During the same tour, Resident R80's roommate, Resident R64, was interviewed. Resident R64 revealed that there was chicken salad on his bedside, which had been brought by a family member. The salad had been opened the previous day, and 75% of it was remaining. He mentioned that he ate some of the salad yesterday but did not refrigerate it. Additionally, he had potatoes brought by a family member, which were not labeled and were also not refrigerated. On March 3, 2025, at 11:56 a.m., an interview was conducted with the unit manager, Employee E4, who confirmed that Resident R80 and Resident R64 had foods that were not appropriately stored. 28 Pa. Code 201.18(b)(1) Management

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 43923 Based on review of facility documentation and interviews with staff, it was determined that the facility failed to maintain an effective, comprehensive, data-driven quality assurance and performance improvement program (QAPI) that focuses on indicators of the outcomes of care and quality of life as required. Findings include: Review facility policy on Quality Assurance and Performance Improvement, (QAPI) last revised on February 2020 reveal that This facility shall develop, implement and maintain and ongoing, facility-wide, data- driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents. It furthers reveals under implementation section 2. The QAPI plan described the process for identifying and correction quality deficiencies. Key components of this process include tracking and measuring performance, establishing goals and threshold for performances measures, identifying and prioritizing quality deficiencies, systematically analyzing underlying causes of systemic quality deficiencies, developing and implementing corrective action or performance improvement activities and monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed. A review of facility QAPI documents revealed no documented evidence that deficient practices identified during previous State surveys where the plan of corrections included using the QAPI process to develop and implemented action plans to correct the identified quality deficiencies. Further there was no documented evidence that the previously identified quality deficiencies were resolved. On March 6, 2025, at 12:55 p.m. Nursing Home Administrator Employee E1 revealed that he could not find any QAPI documentation from the previous Administrator for any of the previously identified quality deficiencies. Further Employee E1 also revealed that there was no documentation available demonstrating the implementation and evaluation of corrective action or performance improvement activities. There was no documentation of meeting minutes for the all the previous months. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18 (b)(1) Management

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347 Based on review of clinical records and staff interview, it was determined that the facility failed to offer and/or provide the influenza and pneumococcal immunization to four of five residents reviewed. (Residents R77, R100, R31, and R78) Findings include: Review of Resident R77's admission Minimum Data Set (MDS- a federal mandated assessment for all residents) dated December 27, 2024, revealed that this resident was admitted to the facility on [DATE], with diagnosis including heart failure and asthma (chronic condition that effects the lungs). Review of Resident R77's immunization record revealed no evidence that this resident received influenza or pneumococcal vaccine or that the facility offered the influenza vaccine or pneumococcal vaccine. Review of Resident R100 admission MDS dated [DATE], revealed that this resident was admitted into the facility on [DATE] with diagnosis' including malnutrition (nutritional deficiency), cerebral vascular incident (stroke, lack of blood flow to the brain), and depression. Review of Resident R100's immunization record revealed revealed no evidence that this resident received influenza or pneumococcal vaccine or that the facility offered the influenza vaccine or pneumococcal vaccine. Review of Resident R31 quarterly MDS dated [DATE], revealed this resident was admitted to the facility on [DATE], with diagnoses of anemia (low levels of red blood cells), renal insufficiency (kidney failure), and asthma (chronic condition that effects the lungs). Review of Resident R31's, immunization record revealed no evidence that this resident received influenza or pneumococcal vaccine or that the facility offered the influenza vaccine or pneumococcal vaccine. Review of Resident R78 quarterly MDS dated [DATE] revealed this resident entered the facility on May 21, 2024 with diagnosis including hypertension (high blood pressure) and malnutrition. Review of resident R 78's, immunization record revealed no evidence that this resident received influenza or pneumococcal vaccine or that the facility offered the influenza vaccine or pneumococcal vaccine. Interview with Director of Nursing, Employee E2, confirmed that there is no documentation of these residents receiving the vaccines. 28 Pa. Code 210.14 (a) Responsibility of licensee 28 Pa. Code 201.18 (b)(1) Management (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.12(c)(d)(10 Nursing services

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 06525 Based on environmental observations of the food and nutriton services department, interviews with residents and staff and reviews of the consulting pest control operator's reports, it was determined that the facility was not maintaining an effective pest control program. Findings include: During a resident council meeting on March 4, 2025, at 10:30 a.m. with 19 residents, (Residents R14, R32, R75, R51, R79, R48, R50, R102, R63, R10, R57, R87, R90, R2, R12, R64, R18, R27, R101) who were identified as being alert and oriented, reported that they are seeing mice in the facility and are reporting to staff for the pest control documentation and treatment. Reviews of the pest control operator's reports for the months of November and December, 2024, January and February, 2025 revealed that the main kitchen and certain resident rooms were being treated for common household pests and rodents. It was noted that the pest control operator was mentioning and documenting voids that need to be filled/addressed in the main kitchen and adjacent hallways and corridors, outside the main kitchen, to prevent pests and rodent entry into the building. Observations of the door adjacent to the main kitchen revealed that the door upon closing was not sealed properly. There was an obvious gap located at the threshold of the metal door. The gap was noted to be two inches by two inches in length and width, allowing easy access for pests and rodents to enter the building. The door adjacent to the main kitchen opened onto the load dock and receiving area of the facility. Situated next to the loading dock was the garbage and trash dumpster unit; where the facility stored its' rubbish for pick up and disposal services. Interview with the nursing home administrator, Employee E1, at 10:45 a.m., on March 6, 2025 confirmed the threshold of the doorway leading outside the building that contained a large void, allowing direct access to the building for pests and rodents. The administrator also confirmed the pest control operator's visits over November and December, 2024, January and February, 2025 that identifed and treated household pests (mice) that had entered the building. 28 Pa. Code 201.18(b)(1)(3)(5)(e)(1)(2.1) Management