

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 02/05/2026
NAME OF PROVIDER OR SUPPLIER Accela Rehab and Care Center at Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE 850 Papermill Road Glenside, PA 19038	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policies, and interviews with residents and staff, it was determined that the facility failed to provide a safe, clean, comfortable and homelike environment for two of two nursing units observed (First Floor and Second Floor). Findings Include: Review of facility policy, Homelike Environment with a revision date of February 2021 states, Policy Statement Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. On February 2, 2026 a tour was taken of the first-floor nursing unit. Several concerns with the physical environment were observed. room [ROOM NUMBER] had a trash can with gloves that were disposed of in it without a trash can liner. room [ROOM NUMBER] had four brown stained drop-down ceiling tiles, frayed electric wires behind the bed, and a had a trash can with food and cups that were disposed of in it without a trash can liner. room [ROOM NUMBER] had a heavily brown stained privacy curtain for the door bed. room [ROOM NUMBER] had one brown stained drop-down ceiling tile, the entire wall beadboard was peeling on the wall next the door bed, and the wall beadboard was peeling off along the exterior wall on the window bed. Along the edge of window there were four glass tiles sitting. There was a whole under the tv for the window bed. There was a electric outlet not fully covered behind the door bed. room [ROOM NUMBER] had two brown stained drop-down ceiling tiles. room [ROOM NUMBER] had five brown stained drop-down ceiling tiles. 28 Pa Code 201.14(a) Responsibility of licensee Observations on February 3, 2026, in the 2-Main nursing unit revealed the following: Observations at 10:15 a.m. revealed the handrail in the hallway, on the wall outside room [ROOM NUMBER], was broken with exposed sharp plastic edges. Subsequently there were two holes in the wall approximately 1inch by 1 inch in size. Observations at 10:26 a.m. revealed the door of Resident R2's nightstand was broken/hanging off. Further, Resident R2 did not have blinds on his/her window.		

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 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 clinical record review, and staff interview, it was determined that the facility failed to ensure that the Office of the State Long-Term Care Ombudsman was notified of facility initiated emergency transfers and discharges for six of six months reviewed. (August, September, October, November, December, January) Review of Resident R93's discharge Minimum Data Set (MDS &ndash; federally mandated resident assessment and care screening) dated January 9, 2026, revealed the resident had an unplanned discharge to the hospital on January 9, 2026. Findings Include: Administration was asked to show proof that the State Long-Term Ombudsman was notified of the facility initiated emergency transfers and discharges for the past four months. A list of dischargers was given for the months requested, but there was no proof of notification to the State Long-Term Care Ombudsman. Interview conducted on February 5, 2026, at 1:55 p.m. with The Social Worker, Employee E3, confirmed that there was no proof of notification of facility-initiated discharges for the last four months requested, October 2025, November 2025, December 2025, and January 2026 . Employee E3 asked when the last time was the discharge lists had been sent and Employee E3 stated February of 2025. 28 Pa. Code 201.14(a) Responsibility of license 28 Pa. Code 201.29(a) Resident Rights		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, clinical record review, review of facility documentation and staff interview, it was determined that the facility failed to adhere to acceptable standards of nursing practice related to medication administration for three of six residents observed during medication administration (Residents R13, R83, R88). The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11(b), General Functions of the Registered Nurse (RN), and 21.14(a), Administration of Drugs, indicated that the RN is fully responsible for all actions as a licensed nurse and is accountable to patients for the quality of care delivered, and administers medication ordered for the patient in the dosage and manner prescribed. The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145(a)(b), Functions of the Licensed Practical Nurse (LPN), indicated that the LPN functions as a member of the health-care team by exercising sound nursing judgement based on preparation, knowledge, experience in nursing and competency, and administers medication ordered for the patient. On February 2, 2026, at 9:53 a.m., observed that Employee E12, a Licensed Nurse, decanted Colace (Docusate) 100MG, two capsules; and Aspirin Chewable 81MG, one tablet for Resident R13. E12 crushed the Aspirin Chewable 81MG tablet in a plastic pouch. E12 opened the Colace (Docusate) capsules and poured the medication into a dispenser- cup. E12 poured the crushed Aspirin Chewable 81MG tablet into the same dispenser cup which had the Colace medication. E12 mixed all the medications with one and half teaspoon of apple sauce and administered half of the mixture to R13 by mouth; and quickly discarded the remaining medications in the dispenser-cup, by throwing it away into the trash can, in R13's room, before being prevented from discarding the half quantity of the medications for R 13. On February 2, 2026, at 9:59 a.m., observed that Employee E12, the Licensed Nurse, decanted Aspirin Chewable tablet 81MG, one tablet; Sertraline HCl tablet 25 MG, three tablets; and Losartan Potassium tablet 100 MG, one tablet. E12 crushed all the medications in a plastic pouch and poured the medications into a plastic dispenser cup and mixed all with one and a half teaspoon of Apple sauce. E12 administered, half of the mixture to R83 by mouth; and initiated to throw away the remaining medications into the trash can in R83's room, but immediately being prevented from discarding the remaining medications, and enquired why did E12 want to discard half the quantity of medications without administering it to R 83; then only E12 did administer the remaining medications to R83. On February 2, 2026, at 10:07 a.m., reviewed the physician order for R13. It revealed an order dated August 30, 2018, to administer Aspirin Chewable tablet 81MG, one tablet. Review of physician order indicated an order dated August 7, 2024, to administer Colace (Docusate) 100MG, two capsules, do not crush or open Colace (Docusate) capsules, switch to tablets if crushing is needed. Reviewed literature, and it indicated as follows: Opening the Docusate Sodium capsule is not recommended due to the potential for throat irritation and the medication's unpleasant taste. Additionally, altering the capsule's form could affect the medication's absorption and efficacy. If the physician has ordered not to open the Colace Capsule, the nurse should follow this instruction to ensure patient safety and medication effectiveness. If the nurse intends to crush the Docusate use tablet form, they should consult with a healthcare provider for guidance on safe usage and potential alternatives. Administering only half the quantity of Docusate sodium to a patient can lead to insufficient stool softening, resulting in harder stools that may cause straining or fecal impaction. The medication's primary function is to soften stool, making it easier to pass, and if not enough is administered, it may not achieve the desired effect, potentially causing discomfort and complications. Therefore, it is crucial for nurses to ensure that the correct dosage is administered to prevent these consequences. Administering only half the quantity of Aspirin 81 can lead to reduced effectiveness in preventing heart attacks and strokes. Aspirin works by reducing blood clot formation, and a lower dose may not provide the same protective benefits. Therefore, it is crucial to ensure that the correct dosage is administered to avoid adverse effects and maintain the medication's therapeutic efficacy. At the time the finding the same was confirmed with E12. On (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	February 2, 2026, at 10:11 a.m., reviewed the physician order for R83. It revealed an order dated March 18, 2025 to administer by mouth Aspirin Chewable tablet 81MG, one tablet, related to Cerebral Infraction; an order dated March 4, 2025, to administer by mouth, Sertraline HCl tablet 25 MG, three tablets, for Major Depressive Disorder; and an order dated May 8, 2023, to administer by mouth, Losartan Potassium tablet 100 MG, one tablet, related to Hypertension. Reviewed literature, and it indicated as follows: Administering only half the quantity of Aspirin 81 can lead to increased risk of bleeding and reduced effectiveness in preventing heart attacks and strokes. Aspirin works by reducing blood clot formation, and a lower dose may not provide the same protective benefits. Therefore, it is crucial to ensure that the correct dosage is administered to avoid adverse effects and maintain the medication's therapeutic efficacy. Administering only half the quantity of Sertraline HCl can lead to inadequate treatment of symptoms, such as depression or anxiety. It can also cause increased risk of side effects, including gastrointestinal issues, sleep disturbances, and mood changes. It is crucial for healthcare providers to ensure that patients receive the appropriate dosage of their medications to avoid these consequences. Administering only half the prescribed dosage of losartan can lead to ineffective antihypertensive treatment, which may result in high blood pressure and increase the risk of stroke. The reason for this consequence is that losartan is a first-line treatment for hypertension, and its effectiveness is directly related to the dosage. Administering a lower dose than prescribed can compromise the medication's ability to lower blood pressure effectively, potentially leading to serious health risks. At the time the finding the same was confirmed with E12. On February 3, 2026, at 8:20 a.m., reviewed the physician order for R88. The physician order dated January 21, 2026, indicated an order to administer Insulin Aspart Injection Solution 100 UNIT/ML (Insulin Aspart), Inject 15 unit subcutaneously with meals related to Type 2 Diabetes Mellitus Without Complications; administer within 15 minutes of meals. The physician order dated August 30, 2025, indicated to administer Insulin Aspart Injection Solution 100 UNIT/ML (Insulin Aspart), Inject as per sliding scale: if 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units, subcutaneously with meals for Insulin-Dependent Diabetes Mellitus (IDDM), administer within 15 minutes of meals. On February 3, 2026, at 8:27 a.m., observed that E13, a Licensed Nurse checked the Blood Sugar (BS) level of R88, and the BS was 218. E13 stated that R88 would get 15 units of Insulin Aspart Injection Solution, and additionally per the sliding scale order, four units of Insulin Aspart Injection Solution 100 UNIT/ML totaling 19 units of Insulin Aspart Injection Solution. On February 3, 2026, at 8:29 a.m., observed that E13 drew Insulin Aspart Injection Solution 100 UNIT/ML. E13 was going to inject the drawn Insulin Aspart Injection Solution to R88, but prevented before injecting it, requested E13 to recheck how many units of Insulin Aspart Injection Solution were drawn in the syringe. E13 rechecked the syringe and found that only 16 units of Insulin Aspart Injection Solution was drawn in the syringe instead of the ordered 19 units of Insulin Aspart Injection Solution. Then, E13 redrew additional 3 units of Insulin Aspart Injection Solution to make the total drawn unit of Insulin Aspart Injection Solution as 19 units. On February 3, 2026, at 8:31 a.m., reviewed literature and it indicated that underdosing Insulin Aspart (administering 16 units instead of the ordered 19 units) primarily results in hyperglycemia (high blood sugar), because the patient is receiving less fast-acting medication than needed to manage their glucose levels, particularly around mealtimes. And it may cause increased thirst, frequent urination, headache, blurry vision, fatigue, and drowsiness etc. At the time of the finding the same was confirmed with E13. The facility failed to adhere to acceptable standards of nursing practice related to medication administration. 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.12(d)(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** Based on review of facility policy, review of clinical records, observations, and staff interview it was determined that the facility failed to maintain personal care needs for dependent residents for one of 28 residents reviewed (Resident R2). Findings Include:Review of facility policy Activities of Daily Living (ADL), Supporting revised March 2018, revealed residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good grooming and personal hygiene.Review of Resident R2's comprehensive Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated January 20, 2026, revealed the resident was rarely/never understood and had diagnoses of dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), adult failure to thrive (a state of decline that is multifactorial and manifested by weight loss, decreased appetite, poor nutrition and inactivity) and muscle weakness.Continued review of Resident R2's MDS dated [DATE], revealed the resident had impairment in functional limitation in range of motion in the upper and lower extremities and was dependent on staff for personal hygiene.Review of Resident R2's comprehensive care plan dated September 5, 2025, revealed the resident was dependent on staff for meeting physical needs related to cognitive deficits.Observations on February 3, 2026, at 10:32 a.m. revealed Resident R2 had bilateral hand contractures (a shortening and stiffening of muscles that limits joint movement). Fingernails (on both hands) were observed to be long and folding in toward the palms.Interview on February 3, 2026, at approximately 10:35 a.m. with Licensed Nurse, Employee E18, confirmed Resident R2 had long fingernails on bilateral hands that required trimming.28 Pa. Code 211.10 (d) Resident care policies.		

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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** Based on record review, interviews, and observation, the facility failed to follow physician orders, failed to monitor and assess residents following changes in condition, failed to ensure consistent wound care, and failed to ensure consistent medication administration for a resident on hospice. (R8, R10, R71) Findings Include: Review of Resident R10's clinical record revealed the resident was admitted to the facility on [DATE]. The resident currently had the following diagnosis: Adult Failure to Thrive (a syndrome, most common in the elderly, characterized by a rapid decline in physical, cognitive, and functional health), Fracture of the Rib (a crack or break in a rib bone), Heart Disease (disease which affects the heart), and Hypertension (a chronic condition defined by consistently high force (130/80 mmHg or higher) of blood against artery walls). Review of Psychological progress note dated January 12, 2026 states, Diagnosis- Generalized anxiety Disorder and Adjustment disorder with mixed anxiety and depressed mood. Further review of the note revealed, Provided emotional validation and active listening as the patient expressed concerns about hospice scheduling and personal care routines. Processed feelings of frustration related to insufficient communication and care from aids, along with challenges she faced in maintaining autonomy in her daily activities. Observation of Resident R10's room revealed at 11:00 a.m. the call bell was turned out and answered by a nurse aide at 11:02 a.m. the nurse aid came out and said that Resident R10 needed to be changed but her aide was not around. At 11:34 a.m. the surveyor went into Resident R10's room to interview them and an interview was held with Resident R10 which revealed the resident was ordered medication for anxiety, but she was not currently getting it. The resident stated, I was getting it for three days, and it was really helping and then one day it just never came, and it has not since then. The resident stated, I am not feeling myself at all, I am sitting here waiting to be changed. Review of Resident 10's clinical record revealed the resident is currently on hospice. Review of Resident R10's physician orders revealed an order from January 13, 2026 for Lorazepam 2mg/ml, give 0.125 ml by mouth in the morning for Anxiety. Review of Resident R10's nursing progress notes reveal several dates that the medication was held and not given due to not having the proper syringe size to administer the medication. The dates that were missing were 1/13, 1/14, 1/16, 1/17, 1/18, 1/19, 1/20, 1/21, 1/22, 1/23, 1/24, 1/25, 1/26, 1/27, 1/31, and 2/2. Review of Resident R8's Minimum Data Set (MDS- a federal mandated assessment) dated November 14, 2025, revealed the resident R8 was admitted to the facility on [DATE], with diagnoses including traumatic brain injury, cerebrovascular accident(stroke), and respiratory failure. The resident was dependent on enteral feeding (tube feeding), required total assistance with all activities of daily living, and received medications including an anticoagulant. Review of Resident R8's the clinical record revealed a nursing progress note dated February 1, 2026, documenting that the resident did not tolerate PEG tube feeding due to emesis(vomiting). the on-call (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician was notified. New orders were received to obtain an abdominal X-ray, CBC, and CMP, and to hold tube feeding until February 2, 2026, pending physician evaluation. Review of the Medication Administration Record (MAR) revealed a scheduled order for enteral feeding every shift from 4:00 PM to 10:00 AM, totaling 1350 mL. Also, a one-time order to hold tube feeding for 24 hours for evaluation of emesis, beginning February 1, 2026, at 7:30 AM. Further review of the resident medication administration record revealed that on February 1, 2026, tube feeding was documented as being held during the morning shift per physician order but was restarted during the evening shift, with documentation indicating 680 mL administered. There was no order for restarting the feeding. Interview conducted on February 5, 2026, at 1:30 PM, a licensed nurse employee E11 confirmed she initiated tube feeding per supervisor instruction. Review of the clinical record revealed a nursing note dated February 2, 2026, documenting that the resident vomited multiple times overnight. Review of nursing notes dated February 3, 2026, revealed that results of the abdominal X-ray performed on February 1, 2026, were received and showed no obstruction. An interview conducted on February 5, 2026, at 12:15 PM, with the Assistant Director of Nursing Employee E4 confirmed she received the X-ray and laboratory results and reported them to the on-call physician by telephone on February 3, 2026. Further review of the clinical record revealed a nursing note dated February 3, 2026, documenting that the resident was observed with coffee-ground emesis. Tube feeding was stopped, the supervisor was notified, EMS was contacted, the resident was transferred to the hospital, and the family was notified. Further review of Residents R8's the clinical record revealed no documented nursing assessments, physician assessments, or medical evaluations from the onset of symptoms on February 1, 2026, until the resident was transferred to the hospital on February 3, 2026. There was no documentation of vital signs, abdominal assessments, or ongoing monitoring during this period. interview with the Director of Nursing employee E2 conducted on February 4, 2026, confirmed that no physician or physician assistant assessments were completed from February 1 through February 3, 2026. Documentation of a telephone interview conducted on February 4, 2026, between the Director of Nursing and the resident's attending physician revealed the attending physician was not notified of the resident's change in condition beginning February 1, 2026 through February 3, 2026 and did not evaluate the resident prior to hospital transfer. Review of resident 71's quarterly Minimum Data Set (MDS) dated December 26, 2025, revealed that resident R71 entered the facility on September 18, 2025, with diagnosis including diabetes. Resident R71 is moderately dependent for ADLs (activities of daily living) and has been assessed of a risk of pressure ulcer. (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 information dated January 12, 2026, submitted by the facility revealed the resident R 71s daughter alleged that the resident's right lower extremity wound care was not completed as ordered and that the resident did not receive consistent assistance with activities of daily living (ADLs). Review of the resident R71's physician wound care orders revealed an order to cleanse the right lateral shin wound with normal saline solution (NSS), apply calcium alginate, and cover with bordered gauze, to be completed every evening shift. Review of the facility's investigation revealed that during an interview conducted on January 14, 2026, a licensed nurse admitted she documented completion of wound care for the resident's right lower extremity on January 13, 2026, during the 3:00 PM&ndash;11:00 PM shift but did not perform the wound care. Personnel documentation of licensed nurse employee E10 revealed the licensed nurse received discipline action of a verbal warning on January 14, 2026, for documenting completion of a treatment that was not performed. The warning was acknowledged and signed by both the employee and the Director of Nursing. Further review of the facility's investigation concluded the allegation of neglect was unsubstantiated, stating the resident missed one day of wound care due to nurse error, and that no negative outcome was identified. During an interview conducted on February 2, 2026, at 10:40 AM, the resident stated that her wound care had been missed on multiple occasions and was not performed consistently. The resident stated she reported the issue to nursing staff and administration, and the issue continued. The resident further stated wound care was typically completed during the evening shift. 28 Pa Code 201.18 (b)(1) Management 28 Pa. Code 201.20 9(a)(5)(6) Staff Development 28 Pa. Code 211.12(c)(1)(5) Nursing Services		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on review of facility policy, resident's clinical record, observation and interview with staff, it was determined that the facility failed to ensure the safety of the resident's environment related to medication found on the floor bedside for one of nineteen residents reviewed. (Resident R5) Findings Include: Review of facility policy titled Adminstrating Medications revised April 2019 states, Policy Statement- Medications are administered in a safe and timely manner, and as prescribed. Review of Resident R2's admission Minimum Data Set (MDS- a federal mandated assessment tool for all residents) dated, revealed Resident R5 was admitted into the facility on December 21, 2024 with the diagnosis of Chronic Heart Failure (a long-term, progressive condition where the heart cannot pump blood efficiently to meet the body's needs), Morbid Obesity (s a chronic, severe disease defined by a Body Mass Index (BMI) , Schizoaffective Disorder (a chronic mental health condition blending schizophrenia symptoms like hallucinations or delusions), Anemia (condition marked by a lack of healthy red blood cells or hemoglobin), and Depression (a serious, common mood disorder causing persistent sadness, loss of interest, and functional impairment). Observation of Resident R5 on February 2, 2026 at 10:49 a.m Revealed a off white colored pill on the floor at the head on the bed for Resident R5. Resident R5 was asked if she administered her own medication and she stated, no I do not. The Assistant Director of Nursing Employee E4 was asked to assist with obtaining the pill from the floor and trying to identify was it was. Employee E4 came to the room at 10:54 a.m. and was able to obtain one off white pill. An interview with Employee E4 revealed they could not identify what the pill was. 28 Pa Code 211 .10 (c) Resident care policies 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, clinical record review, and interviews with staff and residents revealed the facility failed to ensure sufficient nursing staff were available to administer medications in a timely manner, resulting in widespread delayed medication administration, resident complaints, and observed symptoms potentially related to missed or delayed medications for 18 pf 18 resident reviewed. Observation of resident R 81 on February 2, 2026, at approximately 11:20 AM, Resident R81 was observed slumped over against his dresser, appeared to be lethargic, uncomfortable with facial grimacing. Interview with Resident R 81 at time of the above observation revealed that this resident reported feeling wooziness, dizziness, and blurred vision: Interview with Assistant Director of Nursing (ADON) employee E4 at 11:22am on the first-floor unit hallway revealed that she is preparing the morning medication pass for the unit. Employee E4 assessed the resident, including checking blood sugar, and confirmed the resident had not yet received his scheduled morning medications. Employee E4 stated the facility experienced a nurse call-out, resulting in delayed medication administration. The morning medication pass was delayed by several hours beyond scheduled times. Review of resident R81 clinical record physician orders revealed an order for administration at 9:00 AM medications, including Celecoxib 200 mg BID for bilateral hip pain and Metoprolol 50 mg to be administered with food. The resident also reported he had not eaten breakfast. Interview with resident R 90 on February 2, 2026, at 11:45 AM, she reported she had not received morning medications. Review on resident R90's clinical record revealed physician orders Ondansetron for nausea, Eliquis 2.5 mg for DVT, Metoprolol 25 mg BID for hypertension, and Gabapentin 600 mg QID for nerve pain scheduled at 09:00am. The resident reported being in pain while awaiting medications. Interview with R62 revealed that this resident had not received his medications, including Suboxone. review of resident R 62 clinical record physician orders revealed an order for Suboxone to be administered at 09:00 am and every 12 hours and Keppra 750 mg (2 tablets) for seizure management and expressed increasing anxiety while waiting. Observation of first floor nursing unit On February 3, 2026, at 12:05 pm revealed licensed nurse employee E7 preparing medications at the cart confirmed that the morning medications were being administered late, and that the remainder of the unit had not yet received their medications. 28 Pa. Code 201.18 (a)(1)(3) management 28 Pa. Code 201.120 (a)(6) Staff Development 28b Pa. Code 211.12 (c)(d)(3)(5) Nursing Services		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 02/05/2026
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 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. Based on review of Narcotic Shift Count Records, Medication Administration Record, and staff interview, it was determined that the facility failed to implement procedures to promote accurate narcotic medication records on one of three medication carts reviewed. On February 5, 2026, at 10:07 a.m., a review of the Narcotic and Controlled Substances Shift to Shift Count Sheets for the First-Floor Main Medication Cart, and the Medication Administration Record of R43, revealed that even though the medication named Lorazepam 0.5 mg oral tablet was dispensed to R43 on February 1, 2026, at 9 a.m., the same information was not documented in the Narcotic book. Interviewed the charge nurse, an LPN, E14, at the time of the finding, and E14 confirmed the findings. 28 Pa Code 211.9(a)(1)(k) Pharmacy services. 28 Pa Code 211.12 (a)(c)(d)(1)(3)(5) Nursing services.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 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 three of six residents observed during medication administration (Resident R13, R83, R88). On February 2, 2026, at 9:53 a.m., observed that Employee E12, a Licensed Nurse, decanted Colace (Docusate) 100MG, two capsules; and Aspirin Chewable 81MG, one tablet for Resident R13. E12 crushed the Aspirin Chewable 81MG tablet in a plastic pouch. E12 opened the Colace (Docusate) capsules and poured the medication into a dispenser- cup. E12 poured the crushed Aspirin Chewable 81MG tablet into the same dispenser cup which had the Colace medication. E12 mixed all the medications with one and half teaspoon of apple sauce and administered half of the mixture to R13 by mouth; and quickly discarded the remaining medications in the dispenser-cup, by throwing it away into the trash can, in R13's room, before being prevented from discarding the half quantity of the medications for R 13. On February 2, 2026, at 9:59 a.m., observed that Employee E12, the Licensed Nurse, decanted Aspirin Chewable tablet 81MG, one tablet; Sertraline HCl tablet 25 MG, three tablets; and Losartan Potassium tablet 100 MG, one tablet. E12 crushed all the medications in a plastic pouch and poured the medications into a plastic dispenser cup and mixed all with one and a half teaspoon of Apple sauce. E12 administered, half of the mixture to R83 by mouth; and initiated to throw away the remaining medications into the trash can in R83's room, but immediately being prevented from discarding the remaining medications, and enquired why did E12 want to discard half the quantity of medications without administering it to R 83; then only E12 did administer the remaining medications to R83. On February 2, 2026, at 10:07 a.m., reviewed the physician order for R13. It revealed an order dated August 30, 2018, to administer Aspirin Chewable tablet 81MG, one tablet. Review of physician order indicated an order dated August 7, 2024, to administer Colace (Docusate) 100MG, two capsules, do not crush or open Colace (Docusate) capsules, switch to tablets if crushing is needed. Reviewed literature, and it indicated as follows: Opening the Docusate Sodium capsule is not recommended due to the potential for throat irritation and the medication's unpleasant taste. Additionally, altering the capsule's form could affect the medication's absorption and efficacy. If the physician has ordered not to open the Colace Capsule, the nurse should follow this instruction to ensure patient safety and medication effectiveness. If the nurse intends to crush the Docusate use tablet form, they should consult with a healthcare provider for guidance on safe usage and potential alternatives. Administering only half the quantity of Docusate sodium to a patient can lead to insufficient stool softening, resulting in harder stools that may cause straining or fecal impaction. The medication's primary function is to soften stool, making it easier to pass, and if not enough is administered, it may not achieve the desired effect, potentially causing discomfort and complications. Therefore, it is crucial for nurses to ensure that the correct dosage is administered to prevent these consequences. Administering only half the quantity of Aspirin 81 can lead to reduced effectiveness in preventing heart attacks and strokes. Aspirin works by reducing blood clot formation, and a lower dose may not provide the same protective benefits. Therefore, it is crucial to ensure that the correct dosage is administered to avoid adverse effects and maintain the medication's therapeutic efficacy. At the time the finding the same was confirmed with E12. On February 2, 2026, at 10:11 a.m., reviewed the physician order for R83. It revealed an order dated March 18, 2025 to administer by mouth Aspirin Chewable tablet 81MG, one tablet, related to Cerebral Infraction; an order dated March 4, 2025, to administer by mouth, Sertraline HCl tablet 25 MG, three tablets, for Major Depressive Disorder; and an order dated May 8, 2023, to administer by mouth, Losartan Potassium tablet 100 MG, one tablet, related to Hypertension. Reviewed literature, and it indicated as follows: Administering only half the quantity of Aspirin 81 can lead to increased risk of bleeding and reduced effectiveness in preventing heart attacks and strokes. Aspirin works by reducing blood clot formation, and a lower dose may not provide the same protective benefits. Therefore, it is crucial to ensure that the correct dosage is (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered to avoid adverse effects and maintain the medication's therapeutic efficacy. Administering only half the quantity of Sertraline HCl can lead to inadequate treatment of symptoms, such as depression or anxiety. It can also cause increased risk of side effects, including gastrointestinal issues, sleep disturbances, and mood changes. It is crucial for healthcare providers to ensure that patients receive the appropriate dosage of their medications to avoid these consequences. Administering only half the prescribed dosage of losartan can lead to ineffective antihypertensive treatment, which may result in high blood pressure and increase the risk of stroke. The reason for this consequence is that losartan is a first-line treatment for hypertension, and its effectiveness is directly related to the dosage. Administering a lower dose than prescribed can compromise the medication's ability to lower blood pressure effectively, potentially leading to serious health risks. At the time the finding the same was confirmed with E12. On February 3, 2026, at 8:20 a.m., reviewed the physician order for R88. The physician order dated January 21, 2026, indicated an order to administer Insulin Aspart Injection Solution 100 UNIT/ML (Insulin Aspart), Inject 15 unit subcutaneously with meals related to Type 2 Diabetes Mellitus Without Complications; administer within 15 minutes of meals. The physician order dated August 30, 2025, indicated to administer Insulin Aspart Injection Solution 100 UNIT/ML (Insulin Aspart), Inject as per sliding scale: if 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units, subcutaneously with meals for Insulin-Dependent Diabetes Mellitus (IDDM), administer within 15 minutes of meals. On February 3, 2026, at 8:27 a.m., observed that E13, a Licensed Nurse checked the Blood Sugar (BS) level of R88, and the BS was 218. E13 stated that R88 would get 15 units of Insulin Aspart Injection Solution, and additionally per the sliding scale order, four units of Insulin Aspart Injection Solution 100 UNIT/ML totaling 19 units of Insulin Aspart Injection Solution. On February 3, 2026, at 8:29 a.m., observed that E13 drew Insulin Aspart Injection Solution 100 UNIT/ML. E13 was going to inject the drawn Insulin Aspart Injection Solution to R88, but prevented before injecting it, requested E13 to recheck how many units of Insulin Aspart Injection Solution were drawn in the syringe. E13 rechecked the syringe and found that only 16 units of Insulin Aspart Injection Solution was drawn in the syringe instead of the ordered 19 units of Insulin Aspart Injection Solution. Then, E13 redrew additional 3 units of Insulin Aspart Injection Solution to make the total drawn unit of Insulin Aspart Injection Solution as 19 units. On February 3, 2026, at 8:31 a.m., reviewed literature and it indicated that underdosing Insulin Aspart (administering 16 units instead of the ordered 19 units) primarily results in hyperglycemia (high blood sugar), because the patient is receiving less fast-acting medication than needed to manage their glucose levels, particularly around mealtimes. And it may cause increased thirst, frequent urination, headache, blurry vision, fatigue, and drowsiness etc. At the time of the finding the same was confirmed with E13. The facility incurred a medication error rate of 21.43%. Pa Code: 211.12(d)(1)(2)(5) Nursing Services.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and clinical record review, it was determined that the facility failed to correctly administer medications in accordance with physician orders for three of six residents during medication administration observation, resulting in significant medication error (Resident R13, R83, R88), and also the facility failed to ensure medications were administered in accordance with physician orders at the prescribed times, resulting in delayed medication administration for multiple residents, placing them at risk for adverse outcomes. Review of the facility policy titled Administering Medications, revised 2019, revealed that the facility is responsible for ensuring medications are administered safely and timely as prescribed. The policy states that staffing schedules must be arranged to allow medication administration without unnecessary interruptions. Medications are to be administered in accordance with prescriber orders, including required administration timeframes. The policy further states that medication administration times are determined by resident need and therapeutic benefit, not staff convenience. Factors to be considered include achieving optimal therapeutic effect, preventing medication or food interactions, and honoring resident preferences consistent with the care plan. The policy requires that medications be administered within one hour of the prescribed time, unless otherwise specified. Observation and record review revealed that on February 2, 2026, the facility experienced a nursing staff call-out, resulting in delayed morning medication administration on the first-floor nursing unit. Review revealed that 18 of 18 residents on the first-floor nursing unit had not received their scheduled morning medications prescribed to be given at 9:00 a.m. by late morning 11:30a.m. Observation of resident R 81 on February 2, 2026, at approximately 11:20 AM, Resident R81 was observed slumped over against his dresser, appeared to be lethargic, uncomfortable with facial grimacing. Interview with Resident R 81at time of the above observation revealed that this resident reported feeling wooziness, dizziness, and blurred vision Interview with Assistant Director of Nursing (ADON)employee E4 at 11:22am on the first-floor unit hallway revealed that she is preparing the morning medication pass for the unit. Employee E4 assessed the resident, including checking blood sugar, and confirmed the resident had not yet received his scheduled morning medications. Employee E4 stated the facility experienced a nurse call-out, resulting in delayed medication administration. The morning medication pass was delayed by several hours beyond scheduled times. Review of resident R81 clinical record physician orders revealed an order for administration at 9:00 AM medications, including Celecoxib 200 mg BID for bilateral hip pain and Metoprolol 50 mg to be administered with food. The resident also reported he had not eaten breakfast. Interview with resident R 90 on February 2, 2026, at 11:45 AM, she reported she had not received morning medications. Review on resident R90's clinical record revealed physician orders Ondansetron for nausea, Eliquis 2.5 mg for DVT, Metoprolol 25 mg BID for hypertension, and Gabapentin 600 mg QID for nerve pain (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scheduled at 09:00am. The resident reported being in pain while awaiting medications. Interview with R62 revealed that this resident had not received his medications, including Suboxone. review of resident R 62 clinical record physician orders revealed an order for Suboxone to be administered at 09:00 am and every 12 hours and Keppra 750 mg (2 tablets) for seizure management and expressed increasing anxiety while waiting. Observation of first floor nursing unit On February 3, 2026, at 12:05 pm revealed licensed nurse employee E7 preparing medications at the cart confirmed that the morning medications were being administered late, and that the remainder of the unit had not yet received their medications. Staff confirmed a nurse had walked off the shift, preventing timely administration. a similar staffing issue occurred when a nurse walked off the shift, again leaving residents on the first-floor unit without timely morning medications. Review of 13 of 18 residents revealed that they were still awaiting morning medications late into the morning. On February 2, 2026, at 9:53 a.m., observed that Employee E12, a Licensed Nurse, decanted Colace (Docusate) 100MG, two capsules; and Aspirin Chewable 81MG, one tablet for Resident R13. E12 crushed the Aspirin Chewable 81MG tablet in a plastic pouch. E12 opened the Colace (Docusate) capsules and poured the medication into a dispenser- cup. E12 poured the crushed Aspirin Chewable 81MG tablet into the same dispenser cup which had the Colace medication. E12 mixed all the medications with one and half teaspoon of apple sauce and administered half of the mixture to R13 by mouth; and quickly discarded the remaining medications in the dispenser-cup, by throwing it away into the trash can, in R13's room, before being prevented from discarding the half quantity of the medications for R 13. On February 2, 2026, at 9:59 a.m., observed that Employee E12, the Licensed Nurse, decanted Aspirin Chewable tablet 81MG, one tablet; Sertraline HCl tablet 25 MG, three tablets; and Losartan Potassium tablet 100 MG, one tablet. E12 crushed all the medications in a plastic pouch and poured the medications into a plastic dispenser cup and mixed all with one and a half teaspoon of Apple sauce. E12 administered, half of the mixture to R83 by mouth; and initiated to throw away the remaining medications into the trash can in R83's room, but immediately being prevented from discarding the remaining medications, and enquired why did E12 want to discard half the quantity of medications without administering it to R 83; then only E12 did administer the remaining medications to R83. On February 2, 2026, at 10:07 a.m., reviewed the physician order for R13. It revealed an order dated August 30, 2018, to administer Aspirin Chewable tablet 81MG, one tablet. Review of physician order indicated an order dated August 7, 2024, to administer Colace (Docusate) 100MG, two capsules, do not crush or open Colace (Docusate) capsules, switch to tablets if crushing is needed. Reviewed literature, and it indicated as follows: Opening the Docusate Sodium capsule is not recommended due to the potential for throat irritation and the medication's unpleasant taste. Additionally, altering the capsule's form could affect the medication's absorption and efficacy. If the physician has ordered not to open the Colace Capsule, the nurse should follow this instruction to ensure patient safety and medication effectiveness. If the nurse intends to crush the Docusate use tablet form, they should consult with a healthcare provider for guidance on safe usage and potential alternatives. (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administering only half the quantity of Docusate sodium to a patient can lead to insufficient stool softening, resulting in harder stools that may cause straining or fecal impaction. The medication's primary function is to soften stool, making it easier to pass, and if not enough is administered, it may not achieve the desired effect, potentially causing discomfort and complications. Therefore, it is crucial for nurses to ensure that the correct dosage is administered to prevent these consequences. Administering only half the quantity of Aspirin 81 can lead to reduced effectiveness in preventing heart attacks and strokes. Aspirin works by reducing blood clot formation, and a lower dose may not provide the same protective benefits. Therefore, it is crucial to ensure that the correct dosage is administered to avoid adverse effects and maintain the medication's therapeutic efficacy. At the time the finding the same was confirmed with E12. On February 2, 2026, at 10:11 a.m., reviewed the physician order for R83. It revealed an order dated March 18, 2025 to administer by mouth Aspirin Chewable tablet 81MG, one tablet, related to Cerebral Infraction; an order dated March 4, 2025, to administer by mouth, Sertraline HCl tablet 25 MG, three tablets, for Major Depressive Disorder; and an order dated May 8, 2023, to administer by mouth, Losartan Potassium tablet 100 MG, one tablet, related to Hypertension. Reviewed literature, and it indicated as follows: Administering only half the quantity of Aspirin 81 can lead to increased risk of bleeding and reduced effectiveness in preventing heart attacks and strokes. Aspirin works by reducing blood clot formation, and a lower dose may not provide the same protective benefits. Therefore, it is crucial to ensure that the correct dosage is administered to avoid adverse effects and maintain the medication's therapeutic efficacy. Administering only half the quantity of Sertraline HCl can lead to inadequate treatment of symptoms, such as depression or anxiety. It can also cause increased risk of side effects, including gastrointestinal issues, sleep disturbances, and mood changes. It is crucial for healthcare providers to ensure that patients receive the appropriate dosage of their medications to avoid these consequences. Administering only half the prescribed dosage of losartan can lead to ineffective antihypertensive treatment, which may result in high blood pressure and increase the risk of stroke. The reason for this consequence is that losartan is a first-line treatment for hypertension, and its effectiveness is directly related to the dosage. Administering a lower dose than prescribed can compromise the medication's ability to lower blood pressure effectively, potentially leading to serious health risks. At the time the finding the same was confirmed with E12. On February 3, 2026, at 8:20 a.m., reviewed the physician order for R88. The physician order dated January 21, 2026, indicated an order to administer Insulin Aspart Injection Solution 100 UNIT/ML (Insulin Aspart), Inject 15 unit subcutaneously with meals related to Type 2 Diabetes Mellitus Without Complications; administer within 15 minutes of meals. The physician order dated August 30, 2025, indicated to administer Insulin Aspart Injection Solution 100 UNIT/ML (Insulin Aspart), Inject as per sliding scale: if 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units, subcutaneously with meals for Insulin-Dependent Diabetes Mellitus (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(IDDM), administer within 15 minutes of meals. On February 3, 2026, at 8:27 a.m., observed that E13, a Licensed Nurse checked the Blood Sugar (BS) level of R88, and the BS was 218. E13 stated that R88 would get 15 units of Insulin Aspart Injection Solution, and additionally per the sliding scale order, four units of Insulin Aspart Injection Solution 100 UNIT/ML totaling 19 units of Insulin Aspart Injection Solution. On February 3, 2026, at 8:29 a.m., observed that E13 drew Insulin Aspart Injection Solution 100 UNIT/ML. E13 was going to inject the drawn Insulin Aspart Injection Solution to R88, but prevented before injecting it, requested E13 to recheck how many units of Insulin Aspart Injection Solution were drawn in the syringe. E13 rechecked the syringe and found that only 16 units of Insulin Aspart Injection Solution was drawn in the syringe instead of the ordered 19 units of Insulin Aspart Injection Solution. Then, E13 redrew additional 3 units of Insulin Aspart Injection Solution to make the total drawn unit of Insulin Aspart Injection Solution as 19 units. On February 3, 2026, at 8:31 a.m., reviewed literature and it indicated that underdosing Insulin Aspart (administering 16 units instead of the ordered 19 units) primarily results in hyperglycemia (high blood sugar), because the patient is receiving less fast-acting medication than needed to manage their glucose levels, particularly around mealtimes. And it may cause increased thirst, frequent urination, headache, blurry vision, fatigue, and drowsiness etc. At the time of the finding the same was confirmed with E13. Pa Code:211.12(d)(1)(2)(5) Nursing Services.		

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical records, observation, and staff interview it was determined that the facility failed to provide specialized rehabilitative services based on a resident's comprehensive plan of care for one of 19 residents reviewed (Resident R2). Findings Include: Review of Resident R2's comprehensive Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated January 20, 2026, revealed the resident was admitted to the facility on [DATE], was rarely/never understood, and had diagnoses of dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), adult failure to thrive (a state of decline that is multifactorial and manifested by weight loss, decreased appetite, poor nutrition and inactivity) and muscle weakness. Continued review of Resident R2's MDS dated [DATE], revealed the resident had impairment in functional limitation in range of motion in the upper and lower extremities. Review of Resident R2's comprehensive care plan dated January 27, 2026, revealed Resident R2 had positioning deficit related to impairments in range of motion and strength. Observations on February 3, 2026, at 10:32 a.m. revealed Resident R2 had bilateral hand contractures (a shortening and stiffening of muscles that limits joint movement). Resident R2's bilateral hands were observed to lay naturally in a fist. Observations revealed no use of adaptive equipment (include several types of splints and orthotics designed to manage and prevent contractures, improve mobility, and enhance daily functioning) for the contractures. Interview on February 3, 2026, at approximately 10:35 a.m. with Licensed Nurse, Employee E18, confirmed Resident R2 had bilateral hand contractures. Licensed nurse, Employee E18, confirmed the left-hand contracture also appeared worse. Further interview/observations on February 3, 2026, at approximately 10:35 a.m. revealed Licensed nurse, Employee E18, was met with increased resistance when trying to open Resident R2's left fist. Licensed nurse, Employee E18, was unaware of any ordered devices/splints for contractures. Review of Resident R2's clinical record revealed no evidence of care and treatment for the bilateral hand contractures. Review of Resident R2's clinical record revealed a Physical Medicine and Rehabilitation Consult dated September 8, 2025, that assessed the left and right upper extremities as deconditioned. Further review of the assessment revealed the left upper extremity was also described as a increase in tone . left-handed fist, with 3, 4, 5th finger contracture. Further review of Resident R2's Physical Medicine and Rehabilitation Consult dated September 8, 2025, revealed occupational therapy was recommended for functional activities in range of motion, and upper limb strengthening. Interview on February 4, 2026, at approximately 12:36 p.m. with the Director of Rehabilitation, Employee E19, revealed Resident R2 was not seen by Occupational Therapy until January 27, 2026. Further interview on February 4, 2026, at approximately 12:36 p.m. with the Director of Rehabilitation, Employee E19, confirmed there was no assessment or care/treatment for Resident R2's bilateral contractures from the time of his/her admission [DATE] until January 27, 2026. 28 Pa. Code 211.12 (d)(5) Nursing services.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility policy and procedure and interviews with staff, it was determined that the facility failed to maintain an effective infection control program related to hand hygiene, on one of the six Medication Administration Reviews, and Enhanced Barrier Precautions on one of the one Wound Treatment Observations. Review of Resident R3's Annual Minimum Data Set (MDS), a federally mandated assessment tool for all residents, dated November 23, 2025, revealed the resident was admitted to the facility on [DATE]. Diagnoses included peripheral vascular disease (PVD), a condition involving narrowing of the blood vessels that reduces blood flow to the limbs; diabetes mellitus, a chronic condition affecting how the body processes blood glucose; and a Stage IV pressure ulcer of the sacral region, indicating full-thickness tissue loss with extensive tissue destruction over the tailbone area. Observation of wound care being performed on Resident R3 on February 4, 2026, at approximately 4:45 p.m., revealed that Licensed Nurse Employee E8, assisted by Nursing Assistant Employee E9, provided wound care to the resident's sacral region. The wound care included cleansing the wound with appropriate solution, applying dressings to maintain a moist wound environment, and ensuring the area was protected from further injury and potential bacterial contamination. During the procedure, licensed nurse employee E8 and nursing aid Employee E9 were observed wearing gloves; neither staff member wore the required enhanced barrier precaution gown in accordance with facility policy and infection control standards. Interview conducted on February 4, 2026, following the observation, licensed nurse Employee E8, and nursing aid employee E9, both acknowledged that an enhanced barrier precaution gown should have been worn during the wound care procedure. i Review of Facility policy on Medication Administration, and Policy on wound treatment indicated that the staff would follow established infection control procedures such as hand washing, antiseptic technique, masks, gloves, and isolation precautions for administration of medications, and wound treatments as applicable. On February 3, 2026, at 8:29 a.m., during medication administration to Resident R88, Employee E13, a Licensed Nurse; after touching the drawer, medication cart, computer, and medication-blister-pack; without disinfecting her hands; picked medication tablets from the medication-blister-packs; and placed in the medicine- dispensing-cups; with her bare hand. At the time of the finding, E13 confirmed the same. On February 4, 2026, at 11:02 a.m., during wound treatment to Resident R66; Employee E15, and E16, both Licensed Nurses, did not wear Facial Masks, in spite of the care plan insisted to use Enhanced Barrier Precautions while treating R66, as R66 had Tracheostomy and Ventilator. On February 4, 2026, at 11:07 a.m., during wound treatment to Resident R66, the Nurse E15 took a pair of scissors from her pocket; the scissors fell on the floor of R66's room; E15 took the scissors from floor, did not disinfect the scissors; using the unclean scissors, E15 cut gauze roll, and using the same gauze piece, E15 wiped the skin wound of neck of R66. At the time of the finding the same was (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 02/05/2026
NAME OF PROVIDER OR SUPPLIER Accela Rehab and Care Center at Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE 850 Papermill Road Glenside, PA 19038	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed with E15. 28 Pa Code 211.12 (d)(1)(5) Nursing services		