

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395572	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Fairview Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 900 Manchester Road Fairview, PA 16415	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on review of clinical record and facility documents and staff interview, it was determined that the facility failed to ensure that a complete and thorough investigation was performed related to an injury of unknown origin for one of 16 residents reviewed (Resident R1). Findings include: A facility policy entitled Abuse, Neglect, Exploitation, and Misappropriation of Resident Property dated 12/01/25, indicated that: The person investigating the incident should generally take the following actions: interview resident, accused, and all witnesses; obtain a statement from the resident and each witness; and evidence of the investigation should be documented. After completion of the investigation, the evidence should be analyzed; and the Nursing Home Administrator [NHA] will determine if the suspicion is substantiated or unsubstantiated; ensure the involved resident's plan of care is reviewed and revised, as appropriate, consistent with the results of the investigation; determine if modifications to existing policies and procedures [or new policies and procedures] are needed to prevent similar incidents or injuries from occurring in the future; complete staff training, if appropriate, as determined by the results of the investigation; and implement any other measures as deemed necessary by the investigation. Resident R1's clinical record revealed an original admission date of 2/11/25, and readmission date of 11/11/25, with diagnoses that included dependence on renal dialysis [medical treatment that performs the function of the kidneys by removing waste, toxins, and excess fluid from the blood when the kidneys are unable to do so naturally], open wounds of the right foot, stage three kidney disease, and gout [form of arthritis that causes pain and swelling in your joints (usually your big toe)]. Interdepartmental progress notes dated 11/04/25, between revealed that: Resident R1 returned from dialysis at 9:30 a.m. in his/her wheelchair. At approximately 11:00 a.m. staff observed a large amount of blood on the floor and on the left foot with a blood clot to foot, large amount of blood soaked in the sock. A statement made by Resident R1 at that time indicated that the transport staff bumped into the curb when they brought him/her back. Resident's left foot was bleeding heavily from four of five toes. Abrasion present on all four toes. Great toe with a 0.5cm x 1.0cm x 0.1cm open area. The other toes with 0.2cm x 0.3cm x 0.1 cm abrasions. Heavily bleeding from all abrasion areas. Staff were unable to get bleeding on toes to stop. Left great toe had tissue missing from the end of the toe, fourth toe was missing the toenail, and the nail bed was bleeding, second and third toe were bleeding as well. Toes were cleaned and pressure dressing was applied. Departmental progress notes on 11/04/25, at 10:18 p.m. identified staff removing pressure dressing from the left foot toes began to bleed. Area cleansed and rewrapped. Review of email communication dated 11/05/25, between the NHA and the contracted transport company indicated that the driver was unaware of injuries occurring to Resident R1's toes. During an interview on 2/25/26, at 1:35 p.m. the NHA confirmed that he/she was unable to locate further documentation of interviews and investigation notes regarding the injuries to Resident R1's left toes. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18 (b)(1)(3)(e)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12 (d)(1)(2)(5) Nursing services</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 395572	Facility ID: 395572 If continuation sheet Page 1 of 3

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on review of clinical record and facility job descriptions, and staff interview, it was determined that the facility failed to ensure that nursing services met professional standards of quality as required by the Pennsylvania Code Title 49, Professional and Vocational Standards by failing to ensure that a Registered Nurse (RN) conducted assessments for seven of 17 sampled residents requiring transfer to the hospital (Residents R10-R16). Findings include: Review of Title 49, Professional and Vocational Standards, Department of State Chapter 21, State Board of Nursing, indicated that under Responsibilities of the RN, 21.11, General Functions. (a) The registered nurse [RN] assesses human responses and plans, implements and evaluates nursing care for individuals or families for whom the nurse is responsible, and (b) The registered nurse is fully responsible for all actions as a licensed nurse and is accountable to clients for the quality of care delivered. The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals. 21.145 Functions of the LPN [Licensed Practical Nurse], (a) . The LPN participates in the planning, implementation and evaluation of nursing care using the focused assessment in settings where nursing takes place. Review of the facility Job Description for LPNs indicated that the LPN will Administer resident care under the supervision of a RN and/or physician to maintain the highest level of resident care; function within the scope of practice according to the State Board of Nursing; and observe, evaluate, and report any abnormal findings . and any significant changes in condition. Review of the facility Job Description for RNs indicated that the RN will Administer resident care under the supervision of a the Director of Nursing [DON] and/or physician to maintain the highest level of resident care; function within the scope of practice according to the State Board of Nursing; and observe, assess, and report any abnormal findings . and any significant changes in condition. Resident R10's clinical record revealed an admission date of 5/07/24, with diagnoses including arthropathy (any disease or disorder affecting the joints, which can cause pain, swelling, stiffness, and reduced function), sacroiliitis (inflammation in the joints where your spine meets your pelvis), Type 2 Diabetes (condition in which the body cannot use insulin correctly and sugar builds up in the blood) and stroke. On 2/11/26, at 12:45 a.m. Resident R10 fell from his/her bed, sustained injury, and was transferred to the hospital for emergency evaluation and treatment. Resident R11's clinical record revealed an admission date of 1/27/24, with diagnoses including irregular heartbeat, depression, heart disease, and fibromyalgia (long-term condition that involves widespread body pain, fatigue, issues with sleep, memory and mood). On 2/14/26, at 5:12 a.m. Resident R11 fell in the hallway, sustained injury, and was transferred to the hospital for emergency evaluation and treatment. Resident R12's clinical record revealed an admission date of 1/10/26, with diagnoses including kidney stones, displacement of kidney drainage tube, urinary tract infection, and heart failure. On 1/14/26, at 5:22 p.m. Resident R12's kidney drainage tube became displaced and he/she required emergency transfer to the hospital to replace the tube. Resident R13's clinical record revealed an admission date of 6/26/19, with diagnoses including bacterial infection in the blood, heart failure, Type 2 Diabetes, and irregular heartbeat. On 1/14/26, at 12:43 a.m. Resident R13 experienced a change in condition and required transfer to the hospital for emergency evaluation and treatment. Resident R14's clinical record revealed an admission date of 1/20/26, with diagnoses including high blood pressure, emphysema (long term lung condition that causes shortness of breath due to damaged air sacs in the lungs), Type 2</p> <p>(continued on next page)</p>		

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