

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395627	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/05/2025
NAME OF PROVIDER OR SUPPLIER Fairlane Gardens Nursing and Rehab at Reading		STREET ADDRESS, CITY, STATE, ZIP CODE 21 Fairlane Road Reading, PA 19606	

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 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident interview, and a review of facility documentation, it was determined that the facility failed to accommodate resident food allergies one of three sampled residents. (Resident 1)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], and that he was allergic to bananas. On March 31, 2025, a nurse noted that the resident reported that he had been served yogurt containing bananas at dinner. In an interview on April 5, 2025, at 8:30 a.m., the resident stated that he had recently been served yogurt containing bananas, and that it happened several times before. Review of facility investigation documents confirmed that on March 31, 2025, the resident was served yogurt containing bananas and that he ingested a small amount. The facility investigation further revealed that he had been served food containing bananas on three prior occasions.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b) Management.</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
---	-------	-----------