STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395627	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairlane Gardens Nursing and Rehab at Reading	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)
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** Based on clinical record review and staff interview, it was determined that the facility failed to develop a comprehensive care plan to include interventions to meet each resident's medical, physical, mental, and psychosocial needs for two of six sampled residents. (Residents 1, 2)Findings include: Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], and had diagnoses that included acute kidney failure, anxiety, depression, and a history of suicidal ideation (thoughts centered around death or suicide). On February 25, 2026, staff documented that the resident was found outside after climbing out the window. Review of facility documentation dated February 25, 2026, revealed that Resident 1 removed two safety brackets, two screws, pushed the screen out and climbed out the window. On March 2, 2026, the psychology provider (a licensed mental health professional who evaluates and treats mental, emotional, and behavioral disorders through talk therapy, behavioral interventions, and coping strategies without prescribing medications) noted that Resident 1 reported suicidal thoughts and had passive death ideation (a desire to die or thoughts of dying without a specific plan or intent to act on them) and that she might stab herself or take an overdose. On March 2, 2026, a nurse noted that Resident 1 removed her Wander Guard (wander management system) bracelet from her arm while on one to one (1:1) observation. On March 3, 2026, the psychiatry practitioner (a medical provider specializing in diagnosing and treating mental health conditions and may prescribe medications) noted that Resident 1 reported intermittent feelings of anxiety, depression, and hopelessness. On March 6, 2026, staff documented that Resident 1 was agitated, having mood changes, making accusatory statements towards her roommate and staff, and that her attitude would change when talking with family. On March 8, 2026, staff documented that Resident 1 was having mood changes and arguing with staff. On March 9, 2026, the psychology provider noted that Resident 1 reported suicidal thoughts and had passive death ideation that she might stab herself or take an overdose. On March 10, 2026, staff documented that Resident 1 was found to have two metal butter knives at the bedside and walked over to the electrical outlet by the television in the room and attempted to put the knives in the outlet while on 1:1 observation. The care plan failed to address Resident 1's passive death ideation, suicidal thoughts, and destructive behaviors (actions, either intentional or unintentional, that cause harm to oneself or others), and failed to include interventions specific for those behaviors. In an interview on March 24, 2026, at 12:10 p.m., the Director of Nursing confirmed that Resident 1's care plan did not include interventions to address her passive death/suicidal ideation and destructive behaviors. Clinical record review revealed that Resident 2 had diagnoses that included dysphagia (difficulty swallowing), schizophrenia, and dementia. On October 28, 2025, a nurse noted that Resident 2 had a coughing episode in the dining room after obtaining half a sandwich off another resident's plate and consuming it. On November 7, 2025, a nurse noted that Resident 2 was found on the floor turning blue and coughed up a semi-chewed peanut butter sandwich and that the resident had a history of rummaging and taking food from trash cans and pudding from medication carts. There was a physician's order dated November 18, 2025, for the resident to receive a pureed diet. On December 1, 2025, the physician (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordered that Resident 2 use a sippy cup for all drinks and for staff to encourage drinking slowly to prevent choking. On December 1, 2025, a nurse noted that Resident 2 was drinking and would not slow down and began to cough. On December 30, 2025, a nurse noted that Resident 2 ate a peanut butter and jelly sandwich and coughed up unchewed pieces. On February 3, 2026, a nurse noted Resident 2 was observed taking pudding off the medication cart and eating it, and that she was begging for food and water. On February 5, 2026, a nurse noted that Resident 2 was pacing and asking for food and water. On February 9, 2026, a nurse noted that Resident 2 was repeatedly looking for food and fluids. On February 24, 2026, psychiatry noted that Resident 2 had ongoing behaviors that included taking items off carts and had food focused behaviors. On March 16, 2026, Resident 2 was noted as attempting to take water from another resident, resulting in a resident-to-resident physical altercation. On March 19, 2026, a nurse noted that Resident 2 had a choking episode in the dining room. The care plan failed to address Resident 2's food seeking behaviors or develop interventions specific for that behavior until the March 19, 2026, choking incident. In an interview on March 24, 2026, at 12:05 p.m., the Director of Nursing confirmed that Resident 2's care plan did not include interventions to address her food seeking behaviors until March 19, 2026. 28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, review of facility documentation, observation, and resident and staff interviews, it was determined that the facility failed to provide adequate supervision to monitor a resident at risk for elopement (unauthorized departure from the facility) and self-harm for two of six sampled residents (Residents 1and 3). In addition, the facility failed to provide adequate supervision to monitor a resident at risk for choking for one of six sampled residents (Resident 2). These failures resulted in an Immediate Jeopardy situation. Findings include:Review of the facility policy entitled, Frequent Monitoring Policy, last reviewed July 14, 2025, revealed that if a resident was placed on one to one (1:1) monitoring, an assigned staff member must remain with the resident at all times and that documentation of the monitoring would be noted in the medical record. Review of the facility policy entitled, Elopements/Elopement Policy, last reviewed July 14, 2025, revealed that staff were to provide a safe and secure environment for residents and would be proactive in preventing resident elopement. Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], and had diagnoses that included acute kidney failure, anxiety, depression, and history of suicidal ideation (thoughts centered around death or suicide). According to the Minimum Data Set (MDS) assessment (a periodic evaluation of resident care needs) dated February 26, 2026, the resident had no memory impairment and could walk independently. On February 25, 2026, staff documented that the resident was found outside after climbing out the window. Review of facility documentation dated February 25, 2026, revealed that Resident 1 removed two safety brackets, two screws, pushed out the screen and climbed out the window. On February 25, 2026, the physician ordered staff to apply a Wander Guard (an electronic device that prevents doors from opening and/or sounds an alarm) and provide 1:1 supervision due to the resident being an elopement risk. Review of Resident 1's care plan revealed she was at risk for elopement with interventions for 1:1 observation and a Wander Guard. On February 26, 2026, social services documented that Resident 1 was agitated and irritated. On February 27, 2026, the psychiatry practitioner (a medical provider specializing in diagnosing and treating mental health conditions and may prescribe medication) noted that Resident 1 was frustrated and recommended continuing the 1:1, directed staff to administer Depakote (a mood stabilizer) 125 milligrams (mg) twice a day, and observe the resident for mood and behavioral concerns. On March 2, 2026, the psychology provider (a licensed mental health professional who evaluates and treats mental, emotional, and behavioral disorders through talk therapy, behavioral interventions, and coping strategies without prescribing medications) noted that Resident 1 reported suicidal thoughts and had passive death ideation (a desire to die or thoughts of dying without a specific plan or intent to act on them), that she might stab herself or take an overdose. On March 2, 2026, a nurse noted that Resident 1 removed her Wander Guard from her arm while on 1:1 observation. On March 3, 2026, the psychiatry practitioner noted that Resident 1 reported intermittent feelings of anxiety, depression, and hopelessness. On March 6, 2026, staff documented that Resident 1 was agitated, having mood changes, making accusatory statements towards her roommate and staff, and that her attitude would change when talking with her family. On March 8, 2026, staff documented that Resident 1 was having mood changes and arguing with staff. On March 9, 2026, the psychology provider noted that Resident 1 reported suicidal thoughts and had passive death ideation that she might stab herself or take an overdose. On March 10, 2026, staff documented that Resident 1 had two metal butter knives at her bedside and walked over to the electrical outlet by the television in her room and went to put the knives in the outlet while on 1:1 observation. In a written statement dated March 11, 2026, at 3:45 p.m. Nurse Aide (NA)1 stated that Resident 1 demonstrated behavior indicating possible self-harm when Resident 1 obtained butter knives and moved toward the electrical outlet. Later in the shift, while outside with other residents, Resident 1 made a statement (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	about wanting to harm herself. On March 10, 2026, the psychiatry practitioner noted that the resident was agitated, preoccupied, and rigid (had difficulty considering alternative solutions). The provider attempted to redirect the resident when she stated, I wish I was dead. The resident was transferred to the hospital for further evaluation due to suicidal ideation. On March 11, 2026, the resident returned to the facility with 1:1 supervision in place, Wander Guard to the lower leg, and the physician increased the Depakote to 250 mg twice a day. On March 12, 2026, social services noted that the resident continued to be on 1:1 due to climbing out the window and concern for exit seeking and continued to have the wander guard. The resident stated she wanted attention because no one was addressing her hemorrhoid pain, she was unhappy at the facility, and she wanted to go somewhere else. On March 13, 2026, the psychiatry provider noted that the resident was irritable, argumentative, and engaged in behaviors in attempts to control and manipulate her circumstances. On March 17, 2026, the psychology provider noted that Resident 1 had verbal aggression, reported suicidal thoughts, and had passive death ideation that she might stab herself or take an overdose. Resident 1 stated that she stuck knives in the outlet because she was hoping to cause a fire so she could get out of the facility. On March 17, 2026, the psychiatry provider noted that Resident 1 stated her mood was not good, and that she had high levels of anxiety and was frustrated. On March 18, 2026, the medical provider noted that due to Resident 1's destructive behavior, she continued on 1:1 because of agitation, trying to exit the facility, and trying to cause physical destruction to the facility by causing a fire. The Patient Watch Observation Sheet, dated March 23, 2026, was observed on Resident 1's dresser on March 24, 2026, at 11:00 a.m. and was not completed. There was no documented evidence that the 1:1 supervision was in place at all times for the resident, who was at risk for self-harm and elopement. The facility failed to provide adequate supervision and interventions to ensure Resident 1's safety.Observations on March 24, 2026, at 11:49 a.m., revealed that Employee 2 exited the facility through a door at the end of the hallway next to the side 2 dining room. Employee 2 propped the door open. A sign on the door stated that the door was alarmed and to keep the door closed. During that time, Resident 3, walked into the hallway next to the opened door and stated, I don't know why I am here. I don't want to be here. Do you know how I can get out of here? Clinical record review revealed that Resident 3 was admitted to the facility on [DATE], and had diagnoses that included nicotine dependence and cognitive communication deficit. Review of Resident 3's care plan revealed that he was at risk for elopement. The door remained propped open and unsupervised until 11:59 a.m. and continued to pose a safety risk for all residents at risk for elopement.Clinical record review revealed that Resident 2 had diagnoses that included dysphagia (difficulty swallowing), schizophrenia, and dementia. According to the MDS assessment, dated January 28, 2026, the resident had memory impairment, required set up assistance with eating, and could walk without assistance. On November 10, 2025, the physician ordered for staff to monitor Resident 2 during all meal and snack times to ensure she was consuming the proper diet. On November 18, 2025, the physician ordered for Resident 2 to receive a puree texture diet (mechanically altered diet that consists of smooth, soft foods that are easy to swallow). On December 1, 2025, the physician ordered for Resident 2 to have a sippy cup for all drinks and for staff to encourage the resident to drink slowly for choking prevention. Review of Resident 2's current care plan revealed she was at nutritional risk related to dysphagia with the intervention for staff to provide her diet (puree texture) as ordered. On October 28, 2025, a nurse noted that Resident 2 had a coughing episode in the dining room after taking half of a sandwich off another residents plate and consuming it. On November 7, 2025, a nurse noted that Resident 2 was found on the floor turning blue and coughed up a semi-chewed peanut butter sandwich, and that the resident had a history of rummaging and taking food from trash cans and pudding from medication carts. On December 1, 2025, a nurse noted Resident 2 was drinking, would not slow down, and began to cough. On December 30, 2025, a nurse noted that Resident 2 ate a peanut butter and jelly sandwich and coughed up unchewed pieces. On February 3, 2026, a nurse noted that Resident 2 was observed taking pudding off the medication cart and eating it, and that she was begging for food and water. On (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	February 5, 2026, a nurse noted that Resident 2 was pacing and asking for food and water. On February 9, 2026, a nurse noted that Resident 2 was repeatedly looking for food and fluids. On February 24, 2026, psychiatry noted Resident 2 had ongoing behaviors that included taking items off carts and food focused behaviors. On March 16, 2026, a nurse noted that Resident 2 attempted to take water from another resident, resulting in a resident-to-resident physical altercation. On March 19, 2026, a nurse noted that Resident 2 had a choking episode in the dining room.Review of facility documentation dated March 19, 2026, revealed that Resident 2 was observed by staff in the dining room eating a peanut butter and jelly sandwich that she obtained off a cart left in the dining room. Resident 2 alerted therapy staff that she did not feel well, and she was assessed by nursing staff to be choking (drooling, turning blue, and unable to speak). The Life Vac (airway clearance, choking rescue) device was utilized to remove a large piece of sandwich. Observations on March 24, 2026, at 11:29 a.m.revealed that Resident 2 was in the dining room drinking from a regular mug. At 11:47 a.m., staff provided another regular mug containing a beverage to Resident 2. The facility failed to provide the physician ordered adaptive equipment (sippy cup) for safe beverage consumption. The facility failed to provide adequate supervision and interventions to prevent Resident 2 from choking.On March 24, 2026, at 2:10 p.m., the Administrator was notified that the failure to provide adequate supervision to prevent elopement, attempted self harm, and choking constituted an Immediate Jeopardy situation at F689-K, and the Immediate Jeopardy template was provided. The facility was informed that a corrective action plan was required.The facility implemented the following corrective action plan: 1. Resident 1 was placed on 1:1 observation on February 25, 2026.2. Resident 1 was provided plastic utensils beginning on March 11, 2026.3. Resident 1's wander guard placement was checked every shift beginning March 12, 2026.4. An audit was completed on March 24, 2026, of all residents who verbalized wanting to harm themselves.5. The facility will review psychiatry notes and progress notes daily for any changes in behaviors.6. Education was provided to nursing staff on behaviors and self harm on March 24, 2026. Staff must sign and acknowledge the trainings on their next scheduled work day.7. Education was provided to staff on the expectations of 1:1 duties on March 24, 2026. Staff must sign and acknowledge the trainings on their next scheduled work day.8. Staff assigned will complete the 1:1 form.9. Audits will be completed of the psychiatry notes and progress notes to ensure changes in behaviors have interventions in place.10. Resident 2 will be redirected during periods of behavioral symptoms and placed on 1:1 supervision as needed.11. An audit was completed on March 19, 2026, of residents seeking food outside their diets.12. Food trays will no longer be left in the dining room, and food brought to the nursing stations will be taken into the locked pantry beginning March 19, 2026.13. Education was provided to nursing and dietary staff on food distribution and collection on March 19, 2026. Staff must sign and acknowledge the trainings on their next scheduled work day.14. Audits will be completed on food distribution and collection.15. Resident 2 was provided her sippy cup on March 24, 2026.16. An audit was completed on March 24, 2026, to ensure adaptive equipment was available and provided.17. Adaptive equipment will be provided to residents as ordered.18. Education was provided to nursing and dietary staff on providing adaptive equipment on March 24, 2026. Staff must sign and acknowledge the trainings on their next scheduled work day.19. Audits will be completed to ensure adaptive equipment is available and provided.20. The exit door was closed.21. An audit of exit doors was completed on March 24, 2026, to ensure they were secured.22. Education was provided to staff on door security on March 24, 2026. Staff must sign and acknowledge the trainings on their next scheduled work day.23. Audits will be completed to ensure exit doors are secured and not propped open.The survey team validated that the Immediate Jeopardy was removed on March 24, 2026, at 8:00 p.m., through verification of facility training and review of facility procedures following the facility's implementation of the corrective action plan for removal of the Immediate Jeopardy. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1)(3) Management.28 Pa. Code 211.10(c)(d) Resident care policies.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.