STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395690	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Rehabilitation and Healthcare Center	463 West Sproul Road Springfield, PA 19064

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508 Based on review of clinical records, and family member and staff interviews, it was determined that the facility failed to provide confidentiality of residents' personal health information during medication administration for two of three residents reviewed. (Residents R2 and R3). Findings include: Review of facility policy on Confidentiality of information and personal privacy with most recent revision date of October 2017, revealed that under section Policy Statement; our facility will protect and safeguard resident confidentiality and personal privacy. Under section Policy interpretation and implementation #1, the facility will safeguard the personal privacy and confidentiality of all residents and medical records. #4. Access to resident's personal and medical records will be limited to authorized staff and business associates. Interview with complainant revealed that when her husband Resident R1 was discharged home, medical records belonging to 2 other residents were included in her husband's discharge papers. Further complainant revealed that the medical records belonged to Residents R2 and R3. Review of documents provided by complainant via text message during a telephone interview with complainant conducted on April 17, 2025, at 9:02 AM, revealed two documents belonging to 2 residents (Residents R2 and R3). Review of Resident R1's clinical record revealed that Resident R1 was admitted to the facility on [DATE] and discharged to home on March 28, 2025. Review of Resident R2's document revealed a heading Admission Record further, the document contained Resident R2's full name admitted , address, telephone number, sex, date of birth, citizenship, nae of contact persons with their contact information and Resident R2's medical diagnoses. Review of Resident R3's document revealed a heading Admission Record further, the document contained Resident R3's full name admitted , address, telephone number, sex, date of birth, citizenship, nae of contact persons with their contact information and Resident R2's medical diagnoses. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R2's clinical record revealed that Resident R2 was admitted to the facility on [DATE], with diagnoses of but not limited to Non-traumatic Intracerebral Hemorrhage, Essential Hypertension. Review of Resident R3's clinical record revealed that Resident 3 was admitted to the facility on [DATE], with diagnoses of Anoxic Brain Damage, Tracheostomy Status, Chronic Respiratory Failure. Interview with Director of Nursing Employee E1 confirmed that Resident R2 and Resident R3 were residents at the facility. Further Employee E2 also confirmed that the clinical records that were sent together with Resident R1's discharge papers were Resident R2 and Resident R3's face sheet. Further Employee E2 revealed that Resident R2 and Resident R3's medical records should have not been sent with another resident 28 Pa. Code 201.29(j) Resident rights 28 Pa. Code 211.5(b) Clinical Records.