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	04/02/2026

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

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility documentation, and staff interview, it was determined that the facility failed to complete a thorough fall investigation, including obtaining witness statements from the resident and the resident's roommate for one of two residents reviewed for falls. Findings include: Review of Resident R117's clinical record revealed Resident R117 was admitted to the facility on [DATE] with diagnoses of paraplegia (condition where a person loses movement and feeling in the lower half of their body, usually affecting both legs) chronic obstructive pulmonary disease (COPD-prevents airflow to the lungs, causing breathing problems), and chronic pain syndrome. Review of Resident R117's Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs), dated October 23, 2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. Review of facility incident report submitted to department of health, dated November 26, 2025, revealed Resident R117 sustained a fall from bed. Further review revealed CNA was in the room with the resident providing care to the resident and wanted the wound nurse to look at the resident's bottom. Resident was positioned safely in the middle of the bed when the CNA left the room. As staff member went to get wound nurse residents roommate called out that the resident had fallen out of bed. Further review of facility incident report revealed the resident was noted to be bleeding from her head. Resident was kept on the floor until paramedics arrived for safety with RN present. Resident remained alert and oriented, answered questions appropriately. Resident stated she began to slide off the bed and she could not prevent it due to paraplegia. Review of facility investigation, dated November 25, 2026, revealed a witness statement from Employee E7, Nurse Aide, that revealed I was changing resident and I noticed she had an open area on her butt, I left resident on her side with pillows on her side to get (wound nurse) to look at her butt. I felt like she was safe in the bed when I went to get (wound nurse). I heard (wound nurse) walking down the hall, I made sure resident was safe position in the bed before leaving to get (wound nurse). I heard resident call out. Upon returning to room I found the resident on her right side on the floor between the beds. Further review of facility investigation revealed no statements were obtained from Resident R117 or Resident R117's roommate related to the fall incident. Interview on April 1, 2025, at approx. 10:00 a.m. with Employee E1, Director of Nursing, confirmed that there were no written statements obtained from Resident R117 or Resident R117's roommate related to the incident. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.29 (a) Resident rights

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on observations, interview with staff and resident, and review of clinical record and facility's policy, it was determined that facility did not ensure to develop and implement a care plan related to assistive device and fall prevention measures for one of 18 residents reviewed (Resident R69)Findings include: Review of facility policy ?Comprehensive Person-Centered Care Plans,' revised March 2022, indicates that the comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being , including: the resident's stated goals upon admission and desired outcome, and reflects currently recognized standards of practice for problem areas and conditions. Review of Resident R69's clinical record revealed admission date of January 22, 2026, with medical history of chronic obstructive pulmonary disease (disease process that causes decreased ability of the lungs to perform), anxiety disorder, chronic respiratory failure with hypoxia (low levels of oxygen), muscle wasting and atrophy, gait and mobility abnormality. Interview with Resident R69 on Monday, March 30, 2026, at 10:00 am, revealed that she was sound asleep when she rolled out of bed during night shift on March 27, 2026, and had a fall resulting in injury to right eye. Further interview with Resident R69 revealed she previously requested grab bars to be placed on both sides of bed. Review of Resident R69's Interim Bed Rail Evaluation, initiated on January 23, 2026 and completed on February 4, 2026, indicated Resident R69 was ambulatory, has no impaired cognitive status or fluctuations in consciousness, has used bed rail to assist with bed mobility in the past for turning side to side, holding self to one side, pulling self from laying to sitting position, providing sense of security. Further review of Interim Bed Rail Evaluation revealed Resident R69 does not have any uncontrolled or involuntary body movements and does not have poor spatial awareness. Continued review of Interim Bed Rail Evaluation revealed that Resident R69 requested bed rail/safety assistive device to have left grab bar and right grab bar. Review of Resident R69's care plan revealed no evidence of goals and interventions related to grab bars or alternatives to bed rails. 28 Pa Code 211.10(d) Resident care polices 28 Pa. Code 211.12(d)(1)(5) Nursing services

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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 review of clinical records, facility documentation, and staff interviews, it was determined that the facility did not ensure development and implementation of a care plan related to the need for oxygen for 1 of 18 residents reviewed (Resident R10) Findings include:Review of facility policy titled Oxygen Administration, revised October 2010, states one is to verify a physician's order for the procedure in preparation for safe oxygen administration. Review of Resident R10's clinical record revealed that the resident was admitted to the facility on [DATE], with the diagnoses if chronic obstructive pulmonary disease (a progressive lung disease which makes breathing difficult), panlobular emphysema (chronic lung disease with noted uniform destruction of the air sacs used for gas exchange), and mild cognitive impairment. Resident was admitted on hospice care. Observation of Resident R10 on March 30, 2026 at 9:55 AM revealed resident was non-interviewable, was mouth breathing (breathing through the mouth) and on 2 Liters (L) of Oxygen (O2) via O2 concentrator and nasal cannula. Subsequent observations of Resident R10 on April 1, 2026 at 12:47 PM and April 2 at 10:56 AM revealed same. Review of Resident R10's clinical records revealed resident's oxygen saturation had dropped to 78% in the early morning on March 30, 2026, and (she/he) was noted to be dyspneic (having difficulty breathing) and hypoxic (state resulting from having a lack of oxygen in bodily tissues or cells). The resident was placed on a non-rebreather mask, then switched to oxygen via nasal cannula being administered at 4L/minute (min), after oxygen saturation had rebounded to 98% on the non-rebreather. By 9:55 AM that same day when observed, the resident's oxygen had been decreased to 2L/min. Interview with the Director of Nursing, Employee E2, at 9:45 AM on April 1, 2026 confirmed Resident R10 was receiving 2L/min of oxygen via nasal cannula, and revealed her statement that nursing can put patients on oxygen at a rate of 2 Liters per minute without an order but any more than that would require an order. Review of resident's care plan revealed no care plan related to oxygen use/administration. 28 Pa Code 211.10(d) Resident care policies 28 PA. Code 211.12(d)(1)(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 resident interview, review of facility's policy and clinical record, it was determined that facility did not ensure hygiene care was provided as per resident's preference for one of 18 residents reviewed (Resident R86)Findings include: Review of facility policy ?Activities of Daily Living,' revised April 2025, indicates its purpose is to provide residents with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL's). Review of Resident R86's clinical record revealed medical history of falls, multiple sclerosis (autoimmune disorder that affects the central nervous system), fracture of left lower extremity, asthma, muscle wasting and atrophy. Review of R86's Minimum Data Set (MDS- resident assessment of care needs), completed on January 16, 2026, revealed Brief Interview for Mental Status (BIMS) score of 15, which indicated that the resident was cognitive intact. Review of shower schedule for North unit revealed Resident R86 is scheduled for shower during day shift on Wednesdays and Saturdays. Interview with Resident R86 on Monday, March 30, 2026, at 10:30 am, revealed that she was offered a shower three times since admission on [DATE]. Review of Resident R86's plan of care (POC) revealed documented that shower was offered and received on April 1, 2026, at 11:11 am, completed by nurse aide, Employee E6. No evidence of prior history of completed showers as per Resident R86's schedule. Further review of R86's clinical record revealed no evidence of Resident R86 refusing hygiene care, specifically refusal of showers, as per her preference. 28 Pa Code 201.18(b)(1) Management 28 Pa Code 211.10 (d) Resident care policies 28 Pa Code (d)(1) nursing services

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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 review of clinical records, facility documentation, and resident representative and staff interview, it was determined that the facility failed to provide care and services in accordance with professional standards of practice for one of four residents reviewed (Residents R16). Findings include: Review of Resident R16's clinical record revealed Resident R16 was admitted to the facility on [DATE] with a diagnosis of rhabdomyolysis (condition where damaged muscle tissue breaks down quickly and releases harmful substances into the blood), congestive heart failure (CHF- condition where the heart does not pump blood as well as it should, causing fluid to build up in the lungs and other parts of the body like the legs), and chronic kidney disease (long-term condition where the kidneys gradually lose their ability to filter waste and extra fluid from the blood). Review of Resident R16's Nutritional Risk Assessment, dated March 16, 2026, revealed the resident was at risk for malnutrition related to comorbidities. Further review indicated an order for weekly weights x 4. Review of Resident R16's weight records revealed the following: March 14, 2026- 140.6 pounds (lbs.)March 15, 2026- 140.2 lbs.March 30, 2026- 155 lbs. There was no documented weight obtained on or around March 23, 2026, as ordered. Interview on April 2, 2026, at approx. 12:15 p.m. with Resident R16's representative revealed on March 30, 2026, he/she had concern regarding increased swelling in the resident's legs. The representative requested the resident be reweighed and go to the hospital due to concern of CHF exacerbation (worsening of heart failure symptoms, where fluid builds up more than usual in the body, causing problems like shortness of breath, swelling, and rapid weight gain). Once the facility reweighed Resident R16, the resident was noted to have gained approximately 15 pounds since admission. Review of Resident R16's social worker progress note, dated March 30, 2026, revealed resident/family reported concern over leg swelling and wanting to go to hospital. SS (Social Services) notified nursing of request. Review of Resident R16's nurse practitioner progress note, dated March 31, 2026, revealed spoke with patient and (representative) at bedside at length. Concerned about CHF exacerbation. CXR (chest x-ray) done which shows L (left) pleural effusion. On exam, lungs diminished, no wheeze/rhonchi. Trace LE (left leg) edema w/o (without) pain. Pt (patient) and (representative) requested hospitalization. Review of nursing progress notes, dated March 31, 2026, revealed Resident R16 was transferred to the hospital for exacerbation of CHF. Review of nursing progress note, dated April 1, 2026, revealed Resident R16 was admitted to the hospital for acute CHF exacerbation (sudden worsening of heart failure symptoms requiring intervention). Interview on April 2, 2026 at approx. 1:00p.m. with Director of Nursing, Employee E1, confirmed Resident R16's weights were not obtained as ordered on March 23, 2026. 28 PA. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview with residents' and staff, review of policies and review of clinical records, it was determined that facility did not ensure residents' received adequate supervision and assistive device to prevent accidents for two of 18 residents reviewed. (Residents R69, R117) Findings include: Review of facility policy ?Bed Safety and Bed Rails,' revised August 2022, indicates that consideration is given to the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment. Further review of policy indicates that for the purpose of policy, bed rails include side rails, safety rails and grab/assist bars. Prior to the installation or use of a side or bed rail, alternatives to the use of side or bed rails are attempted. Alternatives may include: roll guards, foam bumpers, lowering the bed and/or use of concave mattress to reduce rolling off the bed. Review of Resident R69's Minimum Data Set (MDS- assessment of resident's needs), completed on January 29, 2026, revealed Brief Interview for Mental Status (BIMS) score of 12, which indicated that the resident had moderate cognitive impairment. Further review of Resident R69's fall risk evaluation, completed on January 22, 2026, indicates fall risk score of 12, which indicated the resident was at moderate risk for falls. Review of Resident R69's Interim Bed Rail Evaluation, initiated on January 23, 2026 and completed on February 4, 2026, indicated Resident R69 was ambulatory, had no impaired cognitive status or fluctuations in consciousness, used bed rail to assist with bed mobility in the past for turning side to side, holding self to one side, pulling self from laying to sitting position, providing sense of security. Further review of Interim Bed Rail Evaluation revealed Resident R69 did not have any uncontrolled or involuntary body movements and did not have poor spatial awareness. Resident R69 requested bed rail/safety assistive device to have left grab bar and right grab bar. Observations of Resident R69, on Monday, March 30, 2026, at 10:00 am, revealed Resident R69 in room [ROOM NUMBER] bed A, with a bruise of the right eye. Interview with Resident R69 at the time of the observation revealed that (she/he) was sound asleep when she rolled out of bed during night shift on March 27, 2026, and had a fall resulting in injury to right eye. Further interview with Resident R69 revealed she previously requested grab bars for assistance. Review of facility completed investigation report, completed on March 30, 2026, at 1:42 pm, indicates that while in bed, (she/he) turned on her right side and fell off the bed on to the floor. Review of Resident R69's hospital discharge summary revealed a cat scan of the head completed on March 27, 2026, at 10:19 am, which revealed a small hemorrhagic contusions within the left greater than right anterior cranial fossa; soft tissue hematoma over the right lateral supraorbital soft tissues. Further observations of Resident R69 room environment on Monday, March 30, 2026, at 10:00 am, revealed no evidence of grab bars on bed A in room [ROOM NUMBER]. Interview with Physical Therapy Director, Employee E4, on April 2, 2026 at 10:25 am, revealed that occupational therapist and nursing staff were responsible for initiating order for grab bars and communicating with maintenance employees to implement grab bars for Resident R69. Interview with the Director of Nursing. Employee E1 on March 31, 2026 at approximately 10:30a.m. revealed that it was missed to communicate with maintenance to place bed rails on Resident R69's bed. Review of Resident R117's clinical record revealed Resident R117 was admitted to the facility on [DATE] with diagnoses paraplegia (condition where a person loses movement and feeling in the lower half of their body, usually affecting both legs) chronic obstructive pulmonary disease (COPD- prevents airflow to the lungs, causing breathing problems), and chronic pain syndrome.Review of Resident R117's Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs), dated October 23, 2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact.Review of Resident R117's care plan, dated July 29, 2025, revealed the resident is at risk for (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	falls related to decondition. Review of Resident R117's MDS, dated [DATE], revealed the resident's ability to roll left and right (the ability to roll from lying on back to left and right side, and return to lying on back on the bed) was coded as dependent. Review of facility incident report submitted to the department of health on November 26, 2025, revealed Resident R117 sustained a fall from bed. Further review revealed CAN (nurse aide) was in the room with the resident providing care to the resident and wanted the wound nurse to look at the resident's bottom. Resident was positioned safely in the middle of the bed when the CNA left the room. As staff member went to get wound nurse residents roommate called out that the resident had fallen out of bed. Further review revealed the resident was noted to be bleeding from her head. Resident was kept on the floor until paramedics arrived for safety with RN (registered nurse) present. Resident remained alert and oriented, answered questions appropriately. Resident stated she began to slide off the bed and she could not prevent it due to paraplegia. Review of facility investigation, dated November 25, 2026, revealed a witness statement from Employee E7, Nurse Aide, that revealed I was changing resident and I noticed she had an open area on her butt, I left resident on her side with pillows on her side to get (wound nurse) to look at her butt. I felt like she was safe in the bed when I went to get (wound nurse). I heard (wound nurse) walking down the hall, I made sure resident was safe position in the bed before leaving to get (wound nurse). I heard resident call out. Upon returning to room I found the resident on her right side on the floor between the beds.Review of nurse aide, Employee E7, CNA statement sheet for falls revealed the nurse aide last witnessed Resident R117 in bed lying on her side. Interview on April 1, 2025, at approx. 10:30 a.m. with Employee E1, Director of Nursing, confirmed the nurse aide, Employee E7, left Resident R117 lying on her side in bed when she walked out of the room to get another staff member. 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 211.10(d) Resident care policies 28 PA. Code 211.12(d)(1)(5) Nursing services

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on review of facility assessment and staff interview, it was determined that the facility failed to ensure the direct care staff and input from residents, resident representatives, and/or family members was included when conducting the facility assessment.Findings include: Review of the facility's facility assessment, dated January 09, 2025, revealed there was no indication that the facility involved direct care staff, input from residents, resident representatives, and/or family members. Interview with Employee E1, Administrator, on April 02, 2026, at approximately 10:00 a.m., confirmed there was no direct care staff, resident representatives, and/ or family members included in the facility assessment. 28 Pa. Code 201.18(b)(3) Management28 Pa. Code 211.12(c)(d)(1) 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 review of clinical records, facility documentation, and staff interviews, it was determined that the facility did not ensure a dressing covering a central line was changed as ordered by the physician for one of one resident review with a central line. (Resident R106) Findings Include: Review of Resident R106's clinical record revealed that the resident was admitted to the facility on [DATE] with diagnoses including cutaneous abscess of right lower limb (usually caused by bacterial infection, a collection of pus within or under the skin), extended spectrum beta lactamase (ESBL) resistance (resistance of a specific type of microorganism to a particular type of antibiotics, which cause infection), and methicillin susceptible staphylococcus aureus infection (type of staph infection that can be treated with penicillin-related antibiotics). Review of Resident R106's clinical records revealed Resident R106 was prescribed a course of IV (intravenous) antibiotic Cefazolin sodium starting on March 29, 2026, at 6:00 a.m. to be completed on May 1, 2026. Review of CDC guidelines indicates central lines (CVCs), including Peripherally inserted central venous catheters or PICC, such as the one the patient had, should only be placed when essential, one of the indications including long-term IV therapy which is generally defined as lasting more than a few weeks (can be months). PICC is inserted through a peripheral vein in the arm (basilic or cephalic) with the tip resting in a large central vein near the heart. Further review of CDC guidelines indicate transparent dressings covering the entry site, are to be changed at least every 7 days. Insertion of CVCs is done under sterile technique/procedure and strict infection control practices (eg hand hygiene) are to be followed for care of the line, although one can wear either clean or sterile gloves when the dressing on the line is changed. This is so as to prevent central line-associated bloodstream infections, where germs (bacteria or fungi) enter the bloodstream through a central line. Observation of Resident R106's PICC transparent dressing on April 2, 2026, at 9:04 AM revealed dressing with date 3/25 and initials the initials of person who had changed the dressing. Review of Resident R106's clinical records revealed a one time order for dressing to be changed on March 29, 2026, along with an additional order for dressing to be changed every 7 days, to start on March 30, 2026. Further review of clinical records revealed an updated one time order for the PICC dressing to be changed on April 2, 2026, along with an additional order for dressing change every 7 days, to begin on April 3, 2026. Interview with Infection Preventionist, Employee E8, at 9:08 AM confirmed Resident R106's PICC dressing was dated March 25, 2026. Further observation revealed Unit Manager (North Unit), Employee E5, entered Resident R106's room to change her PICC dressing immediately after Infection Preventionist confirmed the date on the dressing. 28 Pa. Code 211.12 (d)(1)(5) Nursing services