STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395782	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Nursing and Rehabilitation Center	184 Bethlehem Pike Philadelphia, PA 19118

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 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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44882 Based on clinical record review and interview with staff, it was determined that the facility did not develop a comprehensive, person-centered care plan related to wound care for one of nine resident records reviewed (Resident R2). Findings include: Review of clinical documentation revealed that Resident R2 was admitted to the facility on [DATE], and had diagnoses of obesity, gout (a condition which causes pain in the joints, especially those of the feet), muscle weakness, urinary incontinence, and stage three (injuries caused by prolonged pressure on an area of skin, stage three extends through the outer layers of skin and into the tissue underneath) pressure ulcers of the left and right buttocks. Continued review revealed that a skin assessment was completed for Resident R2 upon his admission by licensed nursing staff. This assessment stated, the resident has an open area on his left and right buttock that are dime sized. This assessment was confirmed by the wound specialist, Licensed Nurse Practitioner, Employee E4, in a note written on June 5, 2024, which stated that the resident had stage three pressure wounds on both the left and right glutes which had been present on admission. Review of the care plan for Resident R2 revealed that no care plan had been developed for the resident related to actual wounds. Interview on June 25, 2025, at 3:00 p.m. with the Nursing Home Administrator, Employee E1, and the Director of Nursing, Employee E2, confirmed that no care plan had been developed for Resident R2's wounds. The employees further confirmed that wounds present on admission should be included in the baseline care plan. 28 Pa. Code: 211.12(d)(1)(5) Nursing services

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44882 Based on clinical record review and interview with staff and residents, it was determined that the facility did not ensure that wound care was completed appropriately to treat pressure ulcers for four of five residents with wounds reviewed (Residents R1, R2, R3, and R4). Findings include: Review of clinical documentation for Resident R1 revealed that he was admitted to the facility on [DATE], and had diagnoses of congestive heart failure (a condition in which the heart pumps ineffectively and causes an excess of fluid to build up in the body, especially around the lungs), hypertension (high blood pressure), chronic kidney disease, and gout (a condition which causes pain in the joints, especially those of the feet). Review of wound assessment and treatment notes written by the wound care specialist, Licensed Nurse Practitioner, Employee E4 revealed the following: On June 11, 2024, Employee E4 recommended that Resident R1 receive wound care consisting of, Daily and PRN (as needed) .Cleanse with normal saline .[apply] medical grade honey .[cover with] cdd (clean, dry dressing), for both his left and right heels. These recommendations were repeated on June 18, 2024. Continued review of the resident's clinical record revealed no documented evidence that the physician was made aware of the wound care recommendations. Review of physician orders for Resident R1 revealed that no orders had been placed either for the treatment recommended by Employee E4, or for any other wound care. Review of clinical documentation for Resident R2 revealed that he was admitted to the facility on [DATE], and had diagnoses including obesity, gout, muscle weakness, urinary incontinence, and stage three pressure ulcers of the left and right buttocks. Review of wound assessment and treatment notes written by the wound care specialist, Licensed Nurse Practitioner, Employee E4 revealed the following: On June 5, 2024, Employee E4 recommended that Resident R2 receive wound care consisting of Daily and PRN .Cleanse with normal saline . [apply] medical grade honey . [cover with] cdd, for both his left and right buttocks. Review of physician orders for Resident R2 revealed that orders for the treatment recommended by Employee E4 were not implemented until June 10, 2024, and that prior to that date, no orders had been placed for any other wound care. Review of clinical documentation for Resident R3 revealed that he was admitted to the facility on [DATE], and had diagnoses of malnutrition, repeated falls, iron-deficiency anemia, muscle weakness, and pressure ulcer of the sacral (tailbone) region. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of wound assessment and treatment notes written by the wound care specialist, Licensed Nurse Practitioner, Employee E4 revealed the following: On June 4, 2024, Employee E4 recommended that Resident R3 receive wound care for his sacrum consisting of PRN (as needed), daily .cleanse with normal saline .add collagen powder, medical grade honey . [cover with] cdd, zinc oxide to periwound (area around the wound). These recommendations were repeated on June 11 and 18, 2024. Review of other notes revealed no indication that the physician was made aware of the wound care recommendations. Review of physician orders for Resident R3 revealed that no orders had been placed either for the treatment recommended by Employee E4, or for any other wound care. Review of clinical documentation for Resident R4 revealed that he was admitted to the facility on [DATE], and had diagnoses of acute kidney failure, human immunodeficiency virus (HIV), anemia, and pressure ulcer of the sacral region. Review of wound assessment and treatment notes written by the wound care specialist, Licensed Nurse Practitioner, Employee E4 revealed the following: On June 12, 2024, Employee E4 recommended that Resident R4 receive wound care consisting of Daily and PRN .Cleanse with normal saline . [apply] medical grade honey . [cover with] cdd for his sacrum. These recommendations were repeated on June 18, 2024. Review of other notes revealed no indication that the physician was made aware of the wound care recommendations. Review of physician orders for Resident R4 revealed that no orders had been placed either for the treatment recommended by Employee E4, or for any other wound care. Interview on June 25, 2025, at 3:00 p.m. with the Nursing Home Administrator, Employee E1, and the Director of Nursing, Employee E2, confirmed that wound care orders for these residents had not been entered. 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44882 Based on review of facility policy, observation, clinical record review and interview with staff and residents, it was determined that the facility did not ensure that physician assessments were accurately completed and documented to reflect the actual condition of the residents for four of nine records reviewed (Residents R1, R2, R3, and R4). Findings include: Review of facility policy titled, Physician Visits, revised April 2013, revealed that during physician visits The attending physician must perform relevant tasks .including a review of the resident's total program of care and appropriate documentation. Review of clinical documentation for Resident R1 revealed that he was admitted to the facility on [DATE], and had diagnoses of congestive heart failure (a condition in which the heart pumps ineffectively and causes an excess of fluid to build up in the body, especially around the lungs), hypertension (high blood pressure), chronic kidney disease, and gout (a condition which causes pain in the joints, especially those of the feet). On June 10, 2024, the attending physician, Employee E3 documented an admission assessment which stated the following: Muscle atrophy weakness using wheelchair. The cardiovascular assessment stated no edema present in the extremities. The musculo [sic] assessment stated walks with normal gait for age, and that there was no obvious instability of the lower extremities. The note also stated that lower extremity motor strength is grossly intact. Normal muscle tone bilaterally. Muscle bulk is normal bilaterally. On June 11, 2024, the wound care specialist, Licensed Nurse Practitioner, Employee E4, assessed the resident's ambulation as, out of bed mobility with a wheelchair. Has limited ambulation. The cardiovascular assessment stated, LE (lower extremity; legs) edema noted, described later in the note as +4 pitting (pressure applied to the skin leaves an indent which takes four or more seconds to resolve). The musculoskeletal assessment stated, generalized weakness. Note from Employee E4 on June 18, 2024, documented the same observations, with the exception that the pitting edema was documented as +3. Observations made of Resident R1 on June 25, 2024, at 12:30 p.m. revealed the resident to be unable to stand on his own. Lower extremities had the appearance of edema. Observed resident movement appeared weak. Review of clinical documentation for Resident R2 revealed that he was admitted to the facility on [DATE], and had diagnoses including obesity, gout, muscle weakness, urinary incontinence, and stage three pressure ulcers of the left and right buttocks. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a noted dated June 18, 2024, Licensed Nurse Practitioner, Employee E4 assessed the resident as having gait instability, poor bed mobility. The musculoskeletal assessment stated generalized weakness, left side weak, and decreased ROM (range of motion) left lower extremity. The neuro assessment stated, left sided weakness - left leg contracted (contracture is when a resident's muscles lock in a limb in a bent position, and the resident is no longer able to extend the joint without difficulty, if at all). An assessment by the attending physician, Employee E3, dated June 19, 2024, stated that Resident R2 appears healthy and well developed, muscle atrophy weakness. The Musculo assessment stated walks with normal gait for age. ROM was described as physiologic and symmetric. Upper extremities were described as motor strength is 5/5 bilaterally. Normal muscle tone bilaterally. Lower extremities were described as motor strength is grossly intact. Normal muscle tone bilaterally. Observations made of Resident R2 on June 25, 2024, at 12:15 p.m. revealed the resident to be unable to stand on his own. Upper and lower left extremities appeared to be contracted, with both the arm and leg pulled in toward the body and held rigidly. Observed resident movement appeared weak. Review of clinical documentation for Resident R3 revealed that he was admitted to the facility on [DATE], and had diagnoses of malnutrition, repeated falls, iron-deficiency anemia, muscle weakness, and pressure ulcer of the sacral (tailbone) region. An assessment by the attending physician, Employee E3, dated June 12, 2024, stated that Resident R3 appears healthy and well developed, aphasic with facial drops [sic] decreased range of motion in the back of the neck and multiple joints . left sided weakness. The Musculo assessment stated walks with normal gait for age. ROM was described as physiologic and symmetric. Upper extremities were described as motor strength is 5/5 bilaterally. Normal muscle tone bilaterally. Lower extremities were described as motor strength is grossly intact. Normal muscle tone bilaterally and having no obvious instability. In a note dated June 18, 2024, Licensed Nurse Practitioner, Employee E4 assessed the resident as having gait instability . [and] weakness. Under ambulation, she stated has limited ambulation, impaired mobility. The note also states that the resident had BL (bilateral) LE (leg) contractures; decreased ROM. She also noted that Resident R3 had BLE edema, +2. Observations made of Resident R3 on June 25, 2024, at 2:00 p.m. revealed the resident to be unable to stand on his own. Bilateral lower extremities appeared to be contracted, with both the legs pulled in toward the body and held rigidly. Observed upper extremity movement appeared weak and stiff. The resident stated that before my disability, I never would have looked like this, indicating that he felt that he looked disheveled, and stated that his hands did not work well any longer. The resident stated that due to his condition, he was unable to do many things for himself, including walking and some grooming tasks. Review of clinical documentation for Resident R4 revealed that he was admitted to the facility on [DATE], and had diagnoses including, of acute kidney failure, human immunodeficiency virus (HIV), anemia, and pressure ulcer of the sacral region. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An assessment by the attending physician, Employee E3, dated June 14, 2024, stated that the resident appears healthy and well developed, but also that he had weakness [and] muscle atrophy with decrease ROM. The note also stated Upper extremities: motor strength is 5/5 bilaterally. Normal muscle tone bilaterally. Muscle bulk is normal bilaterally. Lower extremities: motor strength is grossly intact. Normal muscle tone bilaterally. Muscle bulk is normal bilaterally. In a noted dated June 18, 2024, Licensed Nurse Practitioner, Employee E4 assessed the resident as having gait instability, poor bed mobility, generalized weakness and decreased ROM. She also described him as cachectic (appearing weak, with muscle wasting). Observations made of Resident R1 on June 25, 2024, at 1:20 p.m. revealed the resident to be appear weak, with muscles that appeared underdeveloped. Resident was not able to stand and walk during observations. Resident observed with apparent decreased ROM, with movements appearing small and stiff. For all four residents, the physician's documented observations did not reflect the observations of the nurse practitioner or the surveyor. The notes also contained contradictory information within themselves. Interview on June 25, 2025, at 3:00 p.m. with the Nursing Home Administrator, Employee E1, and the Director of Nursing, Employee E2, confirmed that the physician's assessment notes for these residents did not accurately reflect the condition of the residents. 28 Pa. Code:211.2(a) Physician services. 28 Pa. Code 211.5(f) Clinical records.