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	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Rehab and Care 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical records, review of facility documentation, and staff interviews, it was determined that the facility failed to notify the physician of a significant change in the resident's condition for one of three residents reviewed (Resident R1). Findings Include: Review of facility policy Change in a Resident's Condition or Status revised February 2021 revealed the nurse will notify the resident's attending physician, or physician on call, when there has been a significant change in the resident's physical/emotional/mental condition. Per the facility policy, a significant change of condition is a major decline, or improvement, in the resident's status that will not normally resolve itself without intervention. Review of Resident R1's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated July 3, 2025, revealed the resident was readmitted to the facility on [DATE], status post hospitalization. Continued review of Resident R1's MDS dated [DATE], revealed the resident had severe cognitive impairment and had diagnoses of Alzheimer's Disease (progressive brain disorder causing memory loss, cognitive decline, and behavioral changes), depression (persistent feeling of sadness and loss of interest), bradycardia (slow heart rate), altered mental status, and somnolence (sleepiness). Review of Resident R1's clinical record revealed a nursing note dated June 27, 2025, that the resident was readmitted to the facility, from the hospital, and was assessed to be alert, pleasant, cooperative, follows simple commands, and able to make simple needs known. Review of Resident R1 nursing notes dated June 28 and June 29, 2025, revealed the resident was compliant with and tolerated all medications. Continued review of Resident R1's clinical record revealed a nursing note dated July 4, 2025, at 10:20 a.m. by Licensed Nurse, Employee E3, that indicated upon attempt to administer medication, resident appears to be lethargic with very little verbal response. VS [vital signs] WNL [within normal limits] at this time. Review of Resident R1's medication administration revealed the following physician ordered medications were omitted during the day shift of July 4, 2025: cholecalciferol (for osteoporosis), escitalopram (for depression), folic acid (for anemia), furosemide (for swelling), and depakote (for mood disorder). Continued review of Resident R1's clinical record revealed no documented evidence that the physician was notified of this change in condition and subsequent missed medications. Interview on July 25, 2025, at 1:06 p.m. with Licensed Practical Nurse (LPN), Employee E3, revealed Resident R1's baseline upon readmission from him hospitalization June 27, 2025, was lethargic but arousable/responsive and able to get up. Continued interview on July 25, 2025, at 1:06 p.m. with LPN, Employee E3, revealed in the morning of July 4, 2025, when going to administer Resident R1's medications, the resident had a noted change and would barely open his/her eyes. LPN, Employee E3, reported feeling uncomfortable to give medications based on the resident's status. Interview on July 25, 2025, at 1:06 p.m. with LPN, Employee E3, the employee reported that the doctor was called but there was no answer and no return call back. Per LPN, Employee E3, the procedure is to further inform the nursing supervisor if no response is received by the physician. Interview on July 25, 2025, at 1:50 p.m. with Registered Nurse (RN) Supervisor, Employee E4, revealed this employee could not recall if LPN, Employee E3, informed him/her of the nurses inability (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

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	395782	A. Building B. Wing	07/25/2025

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to get in touch with the physician. Continued interview on July 25, 2025, at 1:50 p.m. with RN Supervisor, Employee E4, revealed the physician was not contacted until 4:31 p.m. on July 4, 2025, to inform the physician that Resident R1 appeared to be more lethargic, and that the family was requesting the resident to be sent to the hospital via emergency services. The physician timely responded and gave orders to send Resident R1 to the hospital. Review of Resident R1's clinical record revealed a nursing note dated July 5, 2025, that Resident R1 was subsequently admitted to the hospital with a diagnosis of renal failure (one or both kidneys no longer function well on their own). 28 Pa. Code 211.10 (d) Resident care policies. 28 Pa. Code 211.12 (d)(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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and staff interview it was determined that the facility failed to maintain complete and accurate clinical record documentation for two of three residents reviewed (Resident R1 and R2).Findings Include: Review of Resident R1's clinical record revealed a physician order dated July 2, 2025, for daily respiratory assessment every day shift, which included documentation of lung sounds, pulse and O2 saturation (measures the amount of oxygen in the blood).Continued review of Resident R1's clinical record revealed a nursing note dated July 4, 2025, at 10:20 a.m. by Licensed Nurse, Employee E3, that indicated upon attempt to administer medication, resident appears to be lethargic with very little verbal response. VS [vital signs] WNL [within normal limits] at this time.Review of Resident R1's entire clinical record revealed no documented evidence Licensed Nurse, Employee E3, documented the daily respiratory assessment or what Resident R1's vital signs were on July 3, 2025.Review of Resident R2's clinical record revealed the resident was admitted to the facility on [DATE], and discharged [DATE].Review of Resident R2's medication administration record revealed nursing staff failed to document the administration, or lack thereof, of the following medications that were ordered by the physician to be given on July 19, 2025: levothyroxine (for hypothyroidism), and Klonopin (for schizoaffective disorder).28 Pa. Code 201.14 (a) Responsibility of licensee.28 Pa. Code 211.5 (f)(x) Medical records. 28 Pa. Code 211.5 (f)(xi) Medical records.