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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>395782  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                      | (X3) DATE SURVEY COMPLETED<br><br>08/22/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Fairview Nursing and Rehabilitation Center   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>184 Bethlehem Pike<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |   |  |
| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Respond appropriately to all alleged violations.</p> <p>Based on the review of clinical records and interviews with staff it was determined that the facility failed to ensure a complete and thorough investigation was conducted into a resident's allegation of a fall for 1 out of 2 residents reviewed (Resident R1) Findings include: Review of the August 2025 physician orders for the resident included diagnosis that included hypertension (high blood pressure); cerebral infarction (a stroke); arthritis; history of falling; diabetes (a group of common endocrine diseases characterized by sustained high blood sugar levels); schizophrenia ( a mental disorder characterized variously by hearing voices, having false beliefs that conflict with reality , disorganized thinking or behavior, and flat or inappropriate affect) and substance abuse. Review of a nursing note dated April 5, 2025 at 3:05 p.m. indicated Resident reports falling last week, she states she dose[sic] not remember the day but it was approximately Tuesday at 5am when she fell. She reports slipping on water at left bed side while attempting to walk to wheelchair, hitting her head when she fell. She stated that nursing supervisor and nurse transferred her back to bed. She complains of pain 5/10 to right side of head. [Physician] notified N/o (new order) to obtain x-ray of skull and c-spine. Resident is own responsible party. Review of the resident's clinical record did not show any documented evidence of falls of the entire month of March 2025. During an interview with the Assistant Director of Nursing (ADON) on August 22, 2025, at 11:15 a.m. it was confirmed with the ADON that there was no investigation into the resident's alleged reported fall as communicated by the resident to nursing staff. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 201.29 (a) Resident rights.</p> |   |  |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on the review of clinical records, it was determined that the facility failed to ensure that a person-centered plan of care was developed for a resident with a history of substance abuse for 1 out of 2 residents reviewed (Resident R1). Findings include: Review of Resident R1 August 2025 physician orders revealed the diagnoses of hypertension (high blood pressure); cerebral infarction (a stroke); arthritis; history of falling; diabetes (a group of common endocrine diseases characterized by sustained high blood sugar levels); schizophrenia (a mental disorder characterized variously by hearing voices, having false beliefs that conflict with reality, disorganized thinking or behavior, and flat or inappropriate affect) and substance abuse. Review of the resident's person-centered plan of care included a plan of care dated July 18, 2023, stating that the resident admitted to smoking drugs in her room. Interventions included the use of a smoke detector in the resident's room, restricting the resident's leave of absence visits on a temporary basis, and supervised visitation. Review of a physician's note dated November 15, 2024, at 4:42 p.m. documented that a crack pipe (drug paraphernalia used to smoke crack cocaine) was found in the resident's room. During an interview with the nursing supervisor on August 22, 2025 at 11:53 a.m. revealed that she conducted a room search with the Nursing Home Administrator (NHA) on November 15, 2024 during her 3:00 p.m. through 11:00 p.m. nursing shift and that a crack pipe was found in bags that in the resident's room. The nurse supervisor reported that the resident was asked if she had ever used the crack pipe in the past and the resident reportedly responded, I guess I did now. The nurse supervisor continued the interview and stated that some time last week or the week before, she found what she described as crack cocaine that was stored in a lip balm tube that had been cleared of its original contents inside. Nurse supervisor reported that the resident pulled the lip balm tube from her bra, the resident opened it and said see to the nurse supervisor. The Nurse supervisor stated that she saw white rocks in the lip balm tube that she showed the nurse supervisor. The nurse supervisor reported that she told the resident, that's crack in there, which then the resident closed the lip balm tube up and put it back in her bra. The nurse supervisor reported that she did not take what she thought was crack cocaine in the lip balm tube because another nurse on the shift that she was working told her that she would need a search warrant. During an interview with the NHA on August 22, 2025 at 12:38 p.m. the NHA confirmed the room search with the nursing supervisor was conducted with the resident's permission. The NHA reported that a crack pipe was found, taken out of the resident's room, and that he told the nurse supervisor to go back and resume her regular duties after the room search. Review of a physician's visit note dated October 24, 2024 documented the concern of cocaine and that cessation was strongly encouraged. The physician's note also indicated that the resident will require close monitoring for signs and symptoms of drug abuse, which places the resident at significant risk. #Concern cocaine abuse infacility - Strongly encourage cessation. Pt will require close monitoring for s/s drug abuse which places pt at significant risk. Review of the person-centered plan of care and clinical record did not show evidence of a detailed plan of care that included interventions to prevent the resident's possession of drugs and drug paraphernalia and a plan of care to address supervision of the resident who has a history of substance abuse, and recently suspected of having drug paraphernalia that was taken from her, and suspected drugs in her possession. During a discussion with the NHA and the Director of Nursing (DON) on August 22, 2025 at 2:30 p.m. it was discussed that the resident's care plan did not include detailed interviews for resident supervision and interventions to prevent the resident from obtaining drugs and drugs paraphernalia. 28 Pa Code 211.11(d) Resident care plan 28 Pa. Code 211.12(c)(1) Nursing services 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services</p> |   |  |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on staff interviews, review of facility policy and the review of facility documentation, it was determined that the facility failed to ensure that one resident had a physician's order for a leave of absence from the facility for 1 out of 2 residents reviewed (Resident R1). Findings include: Review of the facility policy, Signing Resident's Out-LOA (Leave of Absence), with a revision date for August 2006 indicated that each resident leaving the premises (excluding transfers and discharges) must be signed out. Review of Resident R1's August 2025 physician orders included the diagnoses of hypertension (high blood pressure); cerebral infarction (a stroke); arthritis; history of falling; diabetes (a group of common endocrine diseases characterized by sustained high blood sugar levels); schizophrenia (a mental disorder characterized variously by hearing voices, having false beliefs that conflict with reality, disorganized thinking or behavior, and flat or inappropriate affect, and other psychoactive), and substance abuse. Review of nursing note dated March 6, 2025 at 9:30 a.m. indicated that the resident out of the facility on a leave of absence visit with her sister with plans to return to the facility in the afternoon. Review of a the physician's note dated March 12, 2025 at 5:41 p.m. stated that the resident had a LOA over the weekend and that the resident had returned to the facility. Review of the resident's August 2025 physician orders did not include a physician's order for the resident to leave the facility on a leave of absence. During an interview with the Nursing Home Administrator (NHA) on August 22, 2025 at 12:28 p.m. it was discussed that the resident had at least two LOA's in March 2025, but there was no physician's order approving the resident's absences from the facility. 28 Pa. Code 211.12 (c) Nursing Services 28 Pa. Code 211.12 (d)(1)(5) Nursing Services</p> |   |  |

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| <p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>Based on observations and interviews with residents and staff, it was determined that the facility failed to ensure that the facility was adequately equipped resident call system for the second floor nursing unit, 7 out of 7 residents reviewed (Resident R1, R2, R3, R4, R5, R6 and R7). Findings include: Review of information submitted to the State Survey Agency on August 4, 2025 indicated that the resident call system at the facility was not working properly, and that some residents had to yell for help. The information submitted also indicated that the facility provided hand-held silver bells for residents to use to shake when they need help, and that such bells cannot be heard from a distance. During interview with Resident R1 and Resident R2's room on August 21, 2025 at 10:20 A.M. both residents reported that their call bells have not worked for quite some time. Resident R1 and Resident R2 reported that they have to yell for help because staff cannot hear them when they ring the silver handheld bells. Resident R1's call bell was not observed in her room during the above referenced observation. When asked where her silver hand held call bell was, she reported that it was gone and stated that someone took it. Resident R2's call bell was out of her reach on a dresser that was across from her bed. She stated, look where they put it. I can't reach over there.' When Resident R1 and Resident R2's call bell system was tested it was found to be non- functional. Observations and testing of resident call system with the maintenance staff, Employee E5 on August 21, 2025, at 11:25 a.m. confirmed that the call system in the resident room or bathroom for Resident R1 and Resident R2 was not working. Observation of Resident R3 on August 21, 2025 at 11:50 a.m. revealed that the resident had a wireless call bell system that was purchased by the facility due to the original facility installed wired call bell system in the resident's room not working. The call bell system transmitted was attached to a black lanyard where is hung on his bed. The wireless call bell system had a digital display screen that was observed at the nursing station. When the wireless call bell transmitter was pressed, the notification can only be heard if you are at the nursing station when the system calls out the room number requesting help. With the above referenced wireless system, facility nursing staff do not have functioning devices in their possession that will notify them of a resident's need for assistance if they are not at the nursing station. No working call light system in the bathroom for Resident R3 was also observed. Observation conducted of Resident R4 and Resident R5 on August 21, 2025 at 11:56 a.m. room also had the above referenced wireless system that worked in the same manner as noted above. No working call light system in the bathroom was observed for Residents R4 and R5. Observation of Resident R6's room on August 21, 2025 at 11:59 a.m. revealed a call bell indicator did not light up above his room when tested, and there was a faint volume at the nursing station. Observation of Resident R7' call bell on Augsut 21, 2025 at 12:05 p.m. revealed that the resident's call bell did not work and the resident was provided a silver hand held bell to ring for assistance. During an interview with Nursing Home Administrator (NHA) on August 21, 2025 at 1:00 p.m. the NHA reported that there have been problems with the facility call bell system on the facility's second floor and some of the first floor due to the system being old and the parts are not able to be replaced. 28 Pa. Code 205.28(c)(1) Nurses' station</p> |   |  |