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	12/10/2025

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Findings Include: A review of the Form Instructions Skilled Nursing Facility (SNF) Advanced Beneficiary Notice of Non-coverage (SNFABN) Form CMS-10055 revealed that examples of the common reasons why an extended care stay, or services may not be covered under Medicare might include the beneficiary no longer requires daily skilled care for a medical condition but wants to continue residing in the skilled nursing facility (SNF). The SNF enters a good faith estimate of the cost of the corresponding care that may not be covered by Medicare. In the blank that follows Beginning on ., the skilled nursing facility enters the date on which the beneficiary may be responsible for paying for care that Medicare is not expected to cover. The beneficiary selects an option box to indicate a desire to continue to receive the care or not to continue to receive the care and if there is a desire to have the bill submitted to Medicare for consideration. The beneficiary or their authorized representative must sign the signature box to acknowledge that they read and understood the notice. The SNF must issue this notice when there is a termination of all Medicare Part A services for coverage reasons. If after issuing the NOMNC, the SNF expects the beneficiary to remain in the facility in a non-covered stay, the SNFABN must be issued to inform the beneficiary of potential liability for the non-covered stay.Review of facility documentation revealed Resident R1 was provided with a notice of Medicare non-coverage that indicated Medicare coverage for facility services would end on September 16, 2025. Resident R1 remained in the facility status post termination of Medicare coverage. Review of facility documentation revealed Resident R2 was provided with a notice of Medicare non-coverage that indicated Medicare coverage for facility services would end on October 17, 2025. Resident R2 remained in the facility status post termination of Medicare coverage. Review of facility documentation revealed Resident R3 was provided with a notice of Medicare non-coverage that indicated Medicare coverage for facility services would end on October 21, 2025. Resident R3 remained in the facility status post termination of Medicare coverage. Continued review of documents provided by the facility revealed no documented evidence Resident R1, R2, and R3 were provided with the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF-ABN; Form CMS-10055) to notify the residents and/or Representative of the cost of the facility's items and services no longer covered under Medicare. Interview on October 29, 2025, at 12:30 p.m. with the Nursing Home Administrator, Employee E1, confirmed Resident R1, R2, and R3 were not provided with the SNF-ABN Form CMS-10055. 29 PA. Code 201.14(a) Responsibility of licensee

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