

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395782	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Fairview Rehab and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and facility policy it was determined that facility failed maintain a safe, clean comfortable and home like environment for residents of one of three nursing units. (First floor and 3rd floor shower room) Findings Include: Facility Policy titled Cleaning and disinfecting Resident's Rooms last revised on August 2013 stated the purpose of this procedure is to provide guidelines for cleaning and disinfecting resident's rooms. Housekeeping surfaces will be disinfected on regular bases and when surfaces are visibly soiled. Under bulletin #6 it stated floor mopping solution will be replaced every three resident rooms or changed no less often than at 60 minutes intervals. Observation of first floor nursing unit on January 6, 2026, 11:34 a.m. revealed there was a strong odor of urine in the hallway of the 1st unit as you get on the unit. Observation of the first-floor nursing unit on January 6, 2026, at 12:09 p.m. revealed a strong odor of urine and feces in the hallway near room [ROOM NUMBER]. The Unit Manager, Employee E4, confirmed there was a significant fecal odor and urine spilled next to bed 129A. Approximately 10 minutes later, Resident R25 arrived in her wheelchair after taking a shower and reported that her Foley catheter had leaked during the night. She stated that her bed, floor, sheets, and surrounding area were soiled and had not yet been cleaned. Observation in room [ROOM NUMBER], Bed C, on January 6, 2026, at 12:27 p.m. revealed a large pile of dried brown bodily fluid consistent with vomit next to Bed C. Nursing Assistant Employee E5 reported that a resident in Bed C vomited earlier that morning and confirmed that the area had not yet been cleaned. The affected resident was not in the room at the time of the interview. Unit Manager Employee E4 confirmed the situation and contacted the Housekeeping Director, Employee E12, who stated that he had not been notified about Rooms 128 or 129. He further reported that nursing staff are responsible for cleaning up bodily fluids and notifying housekeeping to disinfect the area afterward. On January 6, 2026, at 1:30 p.m., observations were conducted with the Housekeeping Director, Employee E12, who confirmed that the first-floor shower room, first shower stall, had a significant amount of hair on the floor, reportedly from a recent haircut. Additionally, the third-floor shower room had dirty socks left behind and a dirty towel on the floor in the first shower stall. On January 7, 2026, at 9:26 a.m., observation of the first-floor nursing unit revealed a strong odor of urine upon entering the unit. The Unit Manager, Employee E4, confirmed the odor and reported that it was coming from room [ROOM NUMBER]. On January 8, 2026, at 9:48 a.m., an observation was conducted with the Administrator, Employee E1, who confirmed the presence of a urine odor and stated that it appeared to be coming from room [ROOM NUMBER]. Upon observation of room [ROOM NUMBER], a urine odor was present. 28 Pa Code: 201.14 (a) Responsibility of licensee.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 395782	Facility ID: 395782 If continuation sheet Page 1 of 5

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review and interviews with staff and residents, it was determined that the facility did not ensure that that professional standards of quality were met related to blood pressure management for one of 32 residents (Resident R36).Based on review of facility policy, clinical record review and interviews with staff and residents, it was determined that the facility did not ensure that that professional standards of quality were met related to blood pressure management for one of 32 residents (Resident R36). Findings include: Review of facility policy Blood Pressure, Measuring, dated September 2010, revealed that Hypertension is usually defined as blood pressure over 140/90 mm/Hg . Hypotension is defined as blood pressure less than 100/60 mm/Hg . Continued review revealed that Hypertension should be reported to the physician. If a resident has a hypertensive reading, staff should record several readings taken at different times of the day, and Hypotension should be reported to the physician. Staff should record several readings throughout the day, including before and after meals. Review of clinical documentation revealed that resident R36 was admitted to the facility on [DATE], with diagnosis including, but not limited to, malignant neoplasm (cancer) of the rectum and colon, and hypertension. The record revealed that at the time of his admission the resident was receiving the following medications for his blood pressure: Amlodipine Besylate Oral Tablet 10 MG.Give 1 tablet by mouth one time a day for High Blood Pressure and Lisinopril oral tablet 40 MG . Give 1 tablet by mouth one time a day for High Blood Pressure. Review of blood pressure measurements for the resident revealed that on September 19th, 2025, at 9:51 a.m. the resident had a blood pressure reading of 86/53, meeting the facility definition of hypotension. No further blood pressure readings are recorded until October 7, 2025. Review of a physician progress notes for resident R36 revealed a note written by the employee E17 on September 20, 2025, at 11:30 a.m. which read BP (blood pressure) running low, d/c ed (discontinued) amlodipine, lisinopril. Review of physician orders revealed that the amlodipine and lisinopril orders were discontinued on September 19, 2025. Continued review of the resident's blood pressure record revealed the following blood pressure measurements which met the definition of either hyper- or hypotensive, and which according to facility policy, required follow-up measurements and communication with the physician: October 7, 2025, at 9:54 a.m., 142/90; on October 14 at 9:30 a.m., 141/97; on December 15 at 9:00 a.m. 166/129; on December 18, at 1:32 p.m. 143/97; on January 4, 2026, at 12:53 p.m., 95/57; on January 6, at 12:40 p.m., 142 / 100. No follow up measurements noted. Review of progress notes Revealed no indication that the physician was informed of these blood pressure readings, or that facility policy to follow up with additional measurements was followed. Interview with employee E16, the Medical Director, on January 9, 2026, at 11:45 a.m., confirmed that the staff had not complied with facility policy related to obtaining additional measurements following abnormal blood pressure reading, and reporting the results to the physician. 28 Pa. Code 211.10 (a)(c) Resident care policies28 Pa. Code 211.12. Nursing services (d)(1)(2)(3)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, facility policy and interviews with residents and staff, it was determined that the facility failed to ensure that the first floor nursing unit was adequately equipped with a functional resident call bell system for one out of the three units observed. (First Nursing Unit). Findings include: A review of the Facility Policy titled Call System, Residents last revised on September 2023 revealed Resident are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. On January 7, 2026, at 9:34 a.m., an interview was conducted with Resident R156, who reported that her call bell was not working. The surveyor tested the call bell and observed that no light was activated at her bedside or outside the room. The call bell for her roommate, Resident R25, was also tested and found not to be functioning. Nursing Assistant Employee E7 confirmed that these call bells were not working. Additional testing revealed that call bells in Rooms 125, 126, 127, 128, 130, and 131 were also not functioning. On January 7, 2026, at 9:53 a.m., an interview was conducted with Licensed Nurse Employee E7, who reported that the call bell at Bed 128B had not been working for the past two months and that the Administrator had provided a small black call bell receiver for temporary use. On January 7, 2026, at 9:58 a.m., an interview with the Unit Manager, Employee E4, revealed that she was not aware that the call bells were not functioning in Rooms 125, 126, 127, 128, 130, and 131. The Unit Manager validated that the call bells were not activating lights or delivering signals to the nursing station to notify staff. On January 7, 2026, at 10:02 a.m., an interview was conducted on the unit with the Administrator, who reported that there had been an issue with some call bells a while ago. He stated that a black call bell receiver had been provided to room [ROOM NUMBER]B until the issue could be resolved. The Administrator further reported that this was the first time he had learned of a major issue with the call bells on the first-floor nursing unit. The maintenance log for the past three months was requested and showed only three tickets related to a call bell issue in room [ROOM NUMBER] on the first floor. The Administrator stated that he plans to shut down the entire call bell system on the first floor and provide separate call bell push buttons connected to a separate black notification box at the nursing station, so staff will be notified when activated. Additionally, nursing staff will conduct 10-minute checks in every room. Further review of the call bell audits revealed that the most recent audit was conducted on September 26, 2025. On January 7, 2026, at 10:30 a.m., a resident council meeting was held with alert and oriented residents (Residents R3, R4, R12, R16, R26, R28, R59, R65, R72, R88, R112, R119, R136, R145, and R146) who reported that call bell issues have been happening for the past a year and half and been functioning on and off. On January 8, 2026, at 10:36 a.m., an interview was conducted with Resident R156, who reported that she was given a small black call bell. However, the call bell was labeled as #17, not with her room number and bed designation. She stated that the nurses on the previous night did not have a key list to identify which resident was assigned to which call bell. As a result, her call was not answered. She also reported that she contacted the receptionist and asked to be transferred to the first-floor nursing station, but her call to the nursing station was never answered. On January 8, 2026, at 10:40 a.m., an interview was conducted with the Administrator, who reported that the nursing station does have a list indicating which residents were assigned alternative call bells. The Administrator stated that when a call bell is activated, nursing staff can identify that call bell #17 is assigned to room [ROOM NUMBER]B. The surveyor and Administrator tested several call bells to ensure they were functioning properly until the main call bell system is repaired. The Administrator also reported that the building is currently being sold to a different</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>company and that resolution of the call bell issues, including any necessary replacements, will be deferred until the new company takes over. On January 9, 2026, at 10:58 a.m., an interview was conducted with Resident R156, who reported that the previous night she used her call bell and it was not answered. She stated that she had to call the receptionist, who then transferred her to the nursing unit desk, where her call was finally answered. On January 9, 2026, at 11:05 a.m., an interview was conducted with the Administrator and the call bell vendor, who had visited the facility a few days earlier to repair the call bell system. The vendor reported that the main call bell box currently needs to be replaced. Once the replacement is completed, they will determine whether the system will function properly or if additional repairs are required. 28 Pa. Code 205.28(c)(1) Nurses' station</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility records, and interviews with staff and residents, it was determined that the facility did not maintain an adequate pest control program related to insects for three of three units reviewed (1st floor, 2nd floor, and 3rd floor).</p> <p>Findings Include:</p> <p>Review of clinical documentation revealed that resident R36 was admitted to the facility on [DATE], with diagnosis including, but not limited to, malignant neoplasm (cancer) of the rectum and colon, and hypertension. Review of his most recent comprehensive MDS (Minimum Data Set- a periodic assessment of resident needs) completed on September 25, 2025, revealed the resident to have a BIMS score (Brief Interview for Mental Status- an assessment of the resident's cognitive state) of 15 out of a possible 15, indicating that he was cognitively intact.</p> <p>During an interview with resident R36 on January 7, 2026, at 10:45 a.m., he revealed that he often saw roaches and other insects in his room and other areas of the building. He stated that he had made the administrator aware of the problem and that pest control services had been ineffective at managing the presence of insects in the facility. Review of clinical record for resident R36 revealed that he was alert and oriented.</p> <p>During an interview on January 7, 2026, at 2:30 p.m., employees E1, the Nursing Home Administrator, and E2, the Director of Nursing, were informed by surveyors of the reports of pests made during the resident council meeting.</p> <p>On January 7, 2026, at 10:30 a.m., a resident council meeting was held with alert and oriented residents (Residents R3, R4, R12, R16, R26, R28, R59, R65, R72, R88, R112, R119, R136, R145, and R146), who reported seeing roaches and mice and stated that they had reported these issues to staff.</p> <p>On January 9, 2026, at 9:39 a.m., an observation on the third floor near the activities office revealed a live roach. This observation was confirmed by the housekeeping aide, Employee E13.</p>		