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	01/09/2026

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

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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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on resident council interview, staff interviews, review of facility policy and reviews of the established mealtime schedule, it was determined that the facility failed to ensure a nourishing snack was provided when 14 hours are between a substantial evening meal and breakfast on the three of three nursing units. (First, Second, and Third Floors).Findings include:A review of the Facility Policy titled Frequency of Meals last revised, March 2017 revealed Each resident shall receive at least three meals daily, at times comparable to typical mealtime in the community or in accordance with resident need, preferences and requests and the plan of care. The facility will serve at least three meals or their equivalent daily at scheduled times. There will not be more than a fourteen-hour span between the evening meal and breakfast. Under bulletin #5 & 6 further revealed Nourishing snacks will be available for residents who need or desire additional food between meals. Evening snack will be offered routinely to all residents. Timing of the snack will consider relevant factors. Residents will also be offered nourishing snack if the time span between the evening meal and the next day's breakfsast exceeds fourteen hours. Nourishing snacks are items from the basic food groups, offered either separately or with each other.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). The residents reported that they rarely, or never, receive a night snack. They stated that when snacks are provided, there are often not enough for everyone, or they do not receive them at all. Residents reported feeling hungry, indicating that the food provided at dinner is insufficient to sustain them until breakfast.On January 8, 2026, at 10:16 a.m., an interview was conducted with Resident R25, who reported that he/she did not receive a snack the previous night.On January 8, 2026, at 10:18 a.m., an interview was conducted with Resident R156 who reported that the last time he/she received a snack was the previous Sunday. Last night, the resident went to the nursing station to request a snack and was informed that no snacks were available.On January 8, 2026, at 10:20 a.m., an interview was conducted with Resident R154, who reported that he/she did not receive a snack the previous night.On January 8, 2026, at 10:21 a.m., an interview was conducted with Nursing Assistant Employee E9, who reported that residents are not provided snacks at night. The employee stated that if residents request additional portions after a meal, they are not available. Employee E9 also reported that food portions are small scoops of each food item served.On January 8, 2026, at 10:25 a.m., an interview was conducted with Licensed Nurse Employee E11, who works the evening shift. Employee E11 reported that during a recent evening shift, there were not enough snacks available for every resident on the floor.On January 8, 2026, at 10:31 a.m., an interview was conducted with the Dietary Director, Employee E8, who confirmed that, based on the scheduled meal times, there is a total of 14 hours and 25 minutes between residents' last dinner, served at 4:50 p.m., and the next breakfast, served at 7:05 a.m., on the first-floor nursing unit. Employee E8 stated that this time interval requires the facility to provide a nutritious snack to each resident. During the observation, dry storage contained items such as sugar cookies, fudge rounds, saltine crackers, Goldfish, and some chips, which were the items available for resident consumption at that time.The (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dietary Director, Employee E8, reported that when snacks are delivered to the nursing units, a sign-off sheet is completed by nursing staff to document receipt of the snacks. A review of the snack documentation revealed no documentation indicating that snacks were delivered on the following dates: November 2, 3, 5, 8, 11, 13, 14, 15, 18, 20, 21, 25, 26, and 27, 2025. Additionally, there were no nursing staff signatures documented for the evening shift on November 6, 2025 ; December 1, 5, 13, 17, 19, 22, 25, and 26, 2025; and January 1, 3, 4, and 6, 2026.28 Pa. Code: 201.14(a) Responsibility of license

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **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.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interviews with residents and staff, and review grievance, it was determined that the facility did not ensure prompt efforts were made to resolve residents' grievances and/or concerns for 1 of 1 resident interviewed (Resident R145) and facility did not share the results of the grievances resolution to 15 of 15 residents reviewed during the resident council (Residents R3, R4, R12, R16, R26, R28, R59, R65, R72, R88, R112, R119, R136, R145, R146).Findings include:On January 6, 2026, at 2:36 p.m., Resident R145 reported that his cell phone was damaged while it was lying on the heating unit in his room. He stated that he notified the Administrator a few months ago and provided an invoice for a replacement cell phone he purchased; however, his grievance had not been resolved. He further reported that he notified the Administrator again on this date and provided a second copy of the invoice.On January 7, 2026, at 10:12 a.m., grievance records dated November 10, 2025, were reviewed. The grievance stated: Resident R145 let admin know cellphone was damaged; wanted reimbursed. Cell phone cost $130 to resident. The grievance was assigned to the Administrator for investigation.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). The residents reported that they file grievances but do not receive resolution to their grievances.On January 8, 2026, at 9:42 a.m., an interview with the Administrator confirmed that the grievance for Resident R145 had not been resolved and that the receipt had just been sent to the corporate office to request payment for the resident's cell phone. The Administrator also confirmed that residents are not notified at the conclusion of grievance investigations. This was further confirmed through review of the grievance binder, which showed that residents were not marked as having been notified of the resolution of their grievances.28 Pa. Code 201.29(a) Resident rights

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility policy and staff interviews, it was determined that the facility failed to ensure that residents were free of misappropriation of resident property related to diversion of narcotic medication for four of four residents reviewed who were prescribed narcotic medications. (Resident R36, R53, R83, R165).Findings include: Review of facility policy Controlled Substances, revised 2022, revealed controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow up. The system of reconciling the receipt, dispensing, and disposition of controlled substances includes the following:Records of personal access and usageMedication administration recordsDeclining inventory recordsDestruction, waste and return to pharmacy records.Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. Review of Resident R83's clinical record revealed Resident R83 was admitted to the facility on [DATE] with a diagnosis of acute kidney failure (kidneys suddenly stop functioning), candidal balanitis (infection or inflammation of the penis head caused by yeast or bacteria), and muscle wasting and atrophy. Review of Resident R83's physician's orders, dated September 28, 2025, revealed an order for Oxycodone HCL 20 mg give 1 tablet by mouth every 6 hours as needed for pain-severe. Review of facility investigation revealed on October 23, 2025 a narcotic audit was completed on P-1 unit. Resident R83's Oxycodone 20 mg medication was noted with tampering to back of blister pack. Three tablets of Oxycodone were removed and replaced with Metoprolol. This was discovered prior to administration of medication. Further audit was completed on all narcotics in the facility and there were two other narcotic diversions noted. Resident R36 Oxycodone 5 mg tabs (20 tabs) were replaced with Namenda. Resident R53 Percocet 5/325 mg (8 tabs) tampered on back of blister pack with Tylenol replacing medication. Review of Employee E14, Registered Nurse, witness statement revealed while performing random narcotic audit Employee E14 noticed a piece of tape on the blister card of oxycodone 5 mg tablet. The pill was noted to be small, round, white, and had U171 imprinted on the pill. Per google it was noted those findings were specific to the medication Namenda. The facility investigation concluded no harm was done to Resident R83, R36, and R53 and no perpetrator was identified. Review of Resident R165's clinical record revealed Resident R165 was admitted to the facility on [DATE] with a diagnosis of malignant neoplasm (cancer- abnormal growth of cells) and neoplasm related to pain (pain can arise from tumor itself or as side effects of cancer treatments). Review of Resident R165's physician's orders, dated May 21, 2025, revealed an order for Oxycodone HCL 10 mg give 1 tablet by mouth every 6 hours as needed for severe pain. Review of facility investigation revealed on May 28, 2025 a narcotic discrepancy was identified for Resident R165's Oxycodone 10 mg PO q6h PRN for severe pain x 3 days; 12 pills in total. Narcotic book was found with page struck out with verbiage, to cart P1, transferred room [ROOM NUMBER]B. Resident did not move rooms. Unit Manager performed cart audit for both front and back medication carts. Missing narcotic was not found. Review of Employee E15, Licensed Practical Nurse, witness statement revealed on May 27, 2025 I counted out the cart with the 11-7 nurse. Count was correct and all blister packs were in the narcotic box. The resident had 12 pills in the blister pack yesterday morning. This morning the whole blister pack was missing and the page in the narcotic book now reads that the medication was transferred to a different cart. Staff unable to locate the medication. Further review of facility investigation revealed the medication was discontinued on May 25, 2025, no harm was done to the resident, and perpetrator was identified. Interview on January 9, 2025 at 9:45 a.m. with Administrator, Employee E1, confirmed the above incidents were substantiated. 28 Pa. Code 201.14(a)(b) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(2)(3) Management 28 Pa. Code 201.29(a) Resident rights

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based upon interviews with facility staff, review of clinical records, facility documentation and policy it was determined that the facility failed to ensure a complete and thorough investigation was completed to rule out neglect when one resident slipped on a wet floor and sustained a fracture for one of 32 resident records reviewed (Resident R90). Findings include:Review of the facility's policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating revised September 2022, states that all allegations are thoroughly investigated and at a minimum, interviews are conducted to any witnesses to the incident and/or staff members (on all shifts) who had contact with the resident during the alleged incident, and documents the investigation completely and thoroughly. Resident R90 was admitted to the facility February 2025, diagnosed with dementia. Facility documentation/investigation revealed on April 19, 2025, the resident suffered a fall that fractured the resident's humerus from a wet floor recently mopped by housekeeping. The documentation stated the Wet floor Sign was present and the resident fall occurred when ambulating to bed. Surveyor interviewed Third floor Unit Manager on January 8, 2026, at 2:30 p.m. and could not answer what the resident was doing or where he was coming from prior to the fall but did state, The resident is very spontaneous We can go into his room, and he will be taken something apart or doing something in his room. He is so spontaneous that if he was coming back from one of his walks, he may not have realized the floor was even wet or noticed that floor sign. Throughout the survey, Resident R90 was observed almost always walking throughout the third-floor unit. Attempting to interview Resident R90 found him pleasantly confused. Resident R90 said he did not remember the wet floor, the fall or healing from the fracture. The resident showed no safety awareness and appeared confused when asked what his response would be if he saw a wet floor or a wet floor sign. Interview with the Assistant Director of Nursing (ADON) a former third floor nurse of Resident R90 who said he knew the resident well stated, Even if the sign was up who is to say he would acknowledge it. The ADON who was part of the investigation and gathered witness statements was asked was the resident entering his room when he fell. ADON agreed he could not answer that question gathered from the investigation. Further review of the investigation revealed the whereabouts of the resident prior to the fall; the placement of the floor sign was not determined and the witness statement from the maintenance staff was not obtained. The investigation to rule out neglect was incomplete. 28 Pa Code 201.14 (a) Responsibility of licensee.

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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** Based on review of clinical records, facility policy, and staff interview, it was determined that the facility failed to develop a baseline care plan within 48 hours of admission that included the minimum information necessary to properly care for one of four resident care plans reviewed (Resident R162). Review of facility policy Care Plans-Baseline, revised 2022, revealed a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following:a. Initial goals based on admission orders and discussion with the resident/representative;b. Physician orders;c. Dietary orders;d. Therapy services;e. Social services; andf. PASARR recommendation, if applicable.Review of Resident 162's clinical record revealed Resident R162 was admitted to the facility on [DATE] with a diagnosis of surgical aftercare following surgery on the circulatory system, hypertension, and pain. Review of Resident R162's care plan revealed Resident R162's baseline care plan was not developed until January 06, 2025 and only addressed Resident R162's nutritional status. Interview on January 9, 2025 at 10:00 a.m. with Employee E3, Assistant Director of Nursing, confirmed Resident R162 did not have a baseline care plan completed within 48 hours of admission. 28 Pa. Code 211.10(d) Resident care policies

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **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)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on review of clinical records, interviews with staff and review of facility documentation revealed the facility failed to give one resident diagnosed with Alzheimer Disease and a history of wandering adequate supervision when found in a restricted area for one of 32 residents (Resident R129).Findings include:Review of Resident R129 clinical records revealed the resident was admitted to the facility diagnosed with Alzheimer disease (a form of dementia with cognitive decline) and a history of wandering in the facility.Nursing note dated September 8, 2025, indicated Resident R129 was witnessed to have retrieved a urine specimen from the specimen fridge and sipped it.Nursing was reeducated on the facility's policy related to Hazardous Areas, Device and Equipment revied in July 2017. Policy defines a hazard as Anything in the environment that has the potential to cause injury or illness .and Open areas or items that should be locked when not in use. Furthermore, the same policy indicates assessment and analysis of hazardous area and equipment will include resident-specific information including identification of vulnerable residents.Interview with the Third floor Unit Manager on January 8, 2026, at 2:00 p.m. explained an aide used the biohazard room where we keep the dirty linen and the refrigerator that stores all the urine samples in the facility. The door locks automatically when you shut it, but it was not shut all the way and left open. The resident was able to get into the room, open the unlocked refrigerator to find the urine samples and drank from one. We now have a lock on the fridge.28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1) Management

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, and interviews with staff and residents, it was determined that the facility did not ensure that medication was administered according to the physician's order for one of 32 residents reviewed (R65).During an interview on January 6, 2026, at 11:30 a.m., resident R65 stated that she had recently been on antibiotic drops for an ear infection, but that she had not received multiple doses. She stated that one of the nurses informed her that the drops could not be located, but the nurse had requested a pharmacy refill. The resident stated that no one ever came back and gave her the missing doses.Review of clinical documentation revealed that resident R65 was admitted to the facility on [DATE], with diagnoses including, but not limited to, asthma, hypertension, and arthritis. Revie of clinical documents revealed that the resident was prescribed Neomycin-polymyxin-HC otic solution 3.5-10,000-1.instill 3 drop[s] in right ear four times a day for Ear Infection for 10 days, indicating a total of 40 doses of the antibiotic drops. The medication was scheduled to be given at 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. starting at 5:00 p.m. on December 24, 2025, with the final dose to be given at 1:00 p.m. on January 3, 2026.Review of the Medication Administration Records (MAR) for December 2025 and January 2026 revealed that the initial two doses of the medication, December 24, at 5:00 p.m. and 9:00 p.m., had not been signed out in the MAR. Additionally, the final two doses, 9:00 a.m. and 1:00 p.m. on January 3, had been signed in the MAR with the numeric code 5, which the MAR identifies as Hold/See Progress Note.Review of the progress notes for resident R65, revealed that licensed nurse, employee E18, entered a note on January 3, 2026, at 11:00 a.m. which stated Medication on HOLD, until pharmacy delivers.Interview with the assistant Director of Nursing, employee E3, on January 9, 2026, at 10:30 a.m. confirmed that the resident had missed four doses of the antibiotic ear drops.28 Pa Code 211.9(a)(1) Pharmacy services28 Pa Code 211.12(d)(5) Nursing services

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	01/09/2026

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **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 2023revelaed 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 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 (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **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). Findings Include: 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. 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. 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. 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. 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.