

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395989	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER Providence Rehab and Hlthcare Ctr at Mercy Fitzgerald		STREET ADDRESS, CITY, STATE, ZIP CODE 600 South Wycombe Ave Yeadon, PA 19050	
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations of care and services, clinical record reviews, reviews of policies and procedures and interviews with staff and residents, it was determined that for each resident reviewed with functional limitations with activities of daily living, the facility failed to ensure that a person-centered care plan related to therapeutic exercises and restorative nursing care was developed and implemented for two of seven residents reviewed. (Residents R118 and R88) Findings include: A review of the facility's policy and procedure titled restorative nursing services dated July 2017 revealed that it was the responsibility of the nursing services department to assess and develop a restorative nursing program to promote optimal safety and independence for each resident. The nursing department, physical therapy department and occupational therapy department was responsible for coordinating the restorative nursing program to meet each resident's care needs. The policy indicated that after discharge from rehabilitative care the resident was assessed for restorative nursing care as needed. The restorative nursing program was developed by the resident and his/her family and the interdisciplinary care team to maintain or improve functioning abilities for activities of daily living. Clinical record review for Resident R118 revealed the nurse practitioner's progress notes on January 12 and 13, 2026 that indicated this resident was cognitively intact. Interview with Resident R118 at 10:00 a.m., on January 11, 2026, revealed that the resident was wondering how often he was supposed to receive physical and occupational therapy services. The resident reported that he had not being out of bed into his chair regularly for therapy activities. Observations of Resident R118 at 10:00 a.m., on January 11, 2026, revealed that this resident was in bed with a right foot wound that was wrapped with kerlix and secured with ace wrap. A review of the physician's orders for October 18, 2025, revealed that physical therapy and occupational therapy services were to evaluate and provided rehabilitation services for Resident R118 five times a week. The therapy department (physical and occupation) indicated on October 19, 2025, that Resident R118 was assessed and required therapy to reposition self in bed, move from supine to sit in bed, bilateral lower extremity exercises for strengthening muscles, upper body dressing assistance, toileting and bathing assistance. Clinical record review revealed that there was no person-centered care plan developed and consistently implemented for physical therapy and occupational therapy for Resident R118 for October 18, 2025, through January 2026. The physician had ordered physical and occupational therapy services for Resident R118 five days a week for October 18 through January 2026. Clinical record review revealed that the physical and occupational therapy services of therapeutic exercises and activities, were not consistently documented as provided for Resident R118 five times a week for October 2025 through January 2026. Clinical record documentation for October 2025 revealed a lack of documentation to indicate that physical/occupational therapy services were provided for Resident R118 on October 23, 24, 25, 26 and 31. Clinical record documentation for November 2025 revealed a lack of documentation to indicate that physical /occupational therapy services were provided on November 4, 7, 8, 9, 16, 18, 22, 23, 25, 27 28, 29, 30 and 31. December 2025 revealed a lack of documentation to indicate physical/occupational therapy was provided on December 2, 4, 6, 9, 10, 16, 17, 18, 20, 25, 26, 27 and 28, 2025. Clinical record review revealed a lack (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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of documentation to indicate that physical/occupational therapy was provided for Resident R118 on January 2, 3, 4, 5 and 6, 2026. Interview with the certified occupational therapy assistant, Employee E6 at 1:00 p.m., on January 12, 2026, confirmed the lack of documentation to indicate that physical and occupational therapy services were provided as ordered by the physician for Resident R118 for October 2025 through January 2026. The certified occupational therapist also confirmed that the facility had not developed a person center care plan to meet the physical and occupational therapy needs of Resident R118 from admission through January 12, 2026. Clinical record review for Resident R88 revealed an admission assessment MDS (an assessment of care needs) dated September 28, 2025, that indicated this resident was alert and oriented, had functional limitations of the lower extremity, used a wheelchair and walker as an assistive device. The assessment said that Resident R88 was non ambulatory for 10 feet of walking. The assessment indicated that resident R88 was requiring maximum assist with staff for sit to standing position and was dependent on staff assistance for chair to bed/ bed to chair transfers and toileting. The assessment indicated that this resident had active diagnoses of right femur fracture and difficulty walking. Clinical record review for Resident R88 revealed that this resident was discharged from physical therapy on December 24, 2025. The therapist indicated on December 24, 2025, that this resident required moderate assistance with wheeled walker for 50 feet of ambulation and required moderate assist of staff with sit to stand transfers with the use of an assistive device. Interview with Resident R88, who was cognitively intact, at 10:30 a.m., on January 12, 2026, revealed that this resident thought that he may need more physical and occupational therapy services. The resident was asking for a program with assistance of staff with transfer from sitting to standing position. The resident was also asking for an exercise program to strengthen the lower extremities for ambulation with the wheeled walker short distances. Observations of Resident R88 at 10:30 a.m., on January 12, 2026, revealed that this resident was in bed with the head of the bed elevated. The resident pointed to a wheelchair in the bed room and said that he could not get into the wheelchair with out staff assistance. Interview with the registered nurse, Employee E5, at 11:30 a.m., on January 12, 2026, confirmed that Resident R88 was not receiving the services of the restorative nursing program since discharged from physical or occupational therapy on December 24, 2025. The registered nurse, Employee E5, also confirmed that the interdisciplinary care team failed to develop and implement a care plan for Resident R88 and his functional impairments with active range of motion care needs.28 PA. Code 211.10(a)(b)(c)(d) Resident care plans28 PA. Code 211.12(d)(1)(2)(3)(5) Nursing services28 PA. Code 201.14(a) Responsibility of licensee No Notes		

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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 record review and review facility policy was determined the facility failed to ensure that medications were administered to residents according to physician's instructions for one of 24 residents reviewed. (Resident R130) Review of facility policy on Administering medications revealed that under section policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Under section Policy Interpretation and Implementation #2. the director of nursing services supervises and directs all personal administer medications and or have related functions. #4. medications are administered in accordance with prescriber orders including any required timeframe. #7. Medications are administered within one hour of their prescribed time unless otherwise specified. Review resident R 130s clinical record revealed that resident R130 was admitted to the facility on [DATE], and was discharged on December 18, 2025. Further review of resident R130 clinical record revealed diagnosis of but not limited to Unilateral Primary Osteoarthritis Right Hip, Presence of Right Artificial Hip Joint, Presence of Right Artificial Shoulder Joint, Low Back Pain, Idiopathic Aseptic Necrosis of Right Humerus. Review resident R 130 physicians order revealed orders for the following medications: Doxycycline Hyclate oral capsules 50mg give two capsules by mouth every 12 hours for wound infection for 6 administrations start date December 16, 2025, Crestor tablet 20mg give one tablet by mouth at bedtime start date December 16, 2025, Omeprazole 40mg capsule delayed release give one capsule by mouth in the morning for GERD start date December 17, 2025, Thyroid Oral Tablet 120 MG (Thyroid) Give 1 tablet by mouth in the morning for Hypothyroidism-Start Date-12/17/2025. Review of resident R 130s MAR (medication administration record) revealed that Crestor oral tablet 20mg one tab by mouth, was coded 22 on December 17, 2025, during the 9pm medication administration schedule. Further, Doxycycline oral capsule 50mg two capsules by mouth was coded 22 on December 16, 2025, during the 9:00AM medication administration schedule and was coded 22 on December 17, 2025, during the 9:00 AM medication administration schedule. Further, Thyroid Oral Tablet 120 MG (Thyroid) 1 tablet by mouth in the morning for Hypothyroidism-Start Date-12/17/2025 06:00AM D/C'd 12/17/25 9:07 PM was coded 22 on December 17, 2025. Further review of Resident R130's MAR revealed that 22 was the code for not administered Further review of Resident R 130th MAR revealed that Omeprazole 40MG capsule was not signed off as given on December 17, 2025. Review of Resident R130's progress note dated December 16, 2025, revealed the following: Doxycycline Hyclate Oral Capsule 50 MG Give 2 capsule by mouth every 12 hours for wound infection for 6 Administrations -On order Review of resident and R 130s progress now dates December 17, 2025, time stamped 6:35 revealed the following: Thyroid Oral Tablet 120 MG Give 1 tablet by mouth in the morning for Hypothyroidism- awaiting delivery Review of Resident R130's Progress not dated December 17, 2025, revealed Doxycycline Hyclate oral capsule 50 mg, give two capsules by mouth every 12 hours for wound infection for 6 administration was not available. Further, progress note indicated awaiting pharmacy. 28 Pa. Code 211.9(a) Pharmacy services		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical records, interview with staff and review of facility policies, it was determined that the facility failed to ensure that residents receive oxygen according to physician's order for one of 24 residents reviewed (Resident R3). Review of facility policy on Oxygen Administration revealed that under section Purpose The purpose of this provide guidelines for safe oxygen administration Preparation #1. Verify that there is a physician's order for this procedure. #2. Review the physician's orders or facility protocol for oxygen administration. Under section Steps in the Procedure #8. Turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters/minute. #10. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. Review of Resident R3 clinical record revealed that Resident R3 was admitted to the facility on [DATE], with diagnosis of but not limited to Chronic Respiratory Failure, Tracheostomy Status Review of Resident R3 physicians order revealed an order for Humidified Air via Trach Collar with Oxygen at 3liters per minute bleed in every shift ordered 10/2/25. Observation on Resident R3 conducted on January 12, 2026, at 9:19 AM revealed that Resident R3 was on oxygen concentrator at 1.75 liters per minute. Follow up observation on Resident R3 conducted on January 13, 2026, at 12:44 PM revealed that Resident R3 was an oxygen concentrator at 1.75 liters per minute. Interview with Respiratory Therapist Employee E7 confirmed that Resident R3's oxygen rate was at 1.75 liters per minute. Further Employee E7 revealed that Resident R3 should be at 3 liters of oxygen per minute. 28 Pa. Code 211.12(c) Respiratory services		