STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395084	A. BLDG: __--_____ B. WING: _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ACCELA REHAB AND CARE CENTER AT SOMERTON STATE LICENSE NUMBER: **131602**	**650 EDISON AVENUE PHILADELPHIA, PA 19116**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on February 24, 2026, at Accela Rehab and Care Center at Somerton, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 0000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

Certified End Page

ACCELA REHAB AND CARE CENTER AT SOMERTON

STATE LICENSE NUMBER: 131602

SURVEY EXIT DATE: 04/30/2026

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395084	A. BLDG: 01 B. WING:	04/30/2026

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ACCELA REHAB AND CARE CENTER AT SOMERTON STATE LICENSE NUMBER: **131602**	**650 EDISON AVENUE PHILADELPHIA, PA 19116**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
K 0000	INITIAL COMMENT Facility ID #131602 Component 01 A, B, and C Wings Based on a Revisit to a Medicare/Medicaid Recertification Survey completed on February 24, 2026, it was determined that Accela Rehab and Care Center at Somerton was not in substantial compliance with the following requirements of the Life Safety Code for an existing nursing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a two-story, Type III (200), unprotected, ordinary building, with three separate basements, that is fully sprinklered.	K 0000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ACCELA REHAB AND CARE CENTER AT SOMERTON STATE LICENSE NUMBER: **131602**	**650 EDISON AVENUE PHILADELPHIA, PA 19116**

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K 0345 SS=F		K 0345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ACCELA REHAB AND CARE CENTER AT SOMERTON	**650 EDISON AVENUE PHILADELPHIA, PA 19116**
STATE LICENSE NUMBER: **131602**	

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K 0345 SS=F	Continued from page 2 NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by:	K 0345	Preparation and /or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed with federal and state law requirements. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. Corrective action 1. Smoke detectors by medical supply room and laundry room have been replaced and hard wired 5/18/26. Facility retrieved and in possession of fire hat and elevator recall key. Shunt trip, Elevator control, tested 4/13/26.Plan Review Department will be contacted for installation of new fire alarm component. 2. Maintenance director or designee to re-educate maintenance staff on the importance of maintaining smoke	Completion Date: **05/18/2026** Status: **APPROVED** Date: **05/20/2026**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0345 SS=F	Continued from page 3	K 0345	detectors and ensuring elevator testing is maintained. 3.Maintenance director or designee to audit laundry rooms and medical supply rooms for smoke detectors weekly X4 monthly X2 4.Maintenance director or designee to audit elevator inspections weekly X4 monthly X2 5.Results will be reviewed at the quarterly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0345 SS=F	Continued from page 4 Based on observation, document review and interview, it was determined the facility failed to maintain fire alarm system components in operable condition, affecting the entire facility. Findings Include: 1. Documentation reviewed on February 24, 2026, at 9:15 a.m., revealed the fire alarm report dated October 21, 2025, listed devices that were not tested but were also not listed in the Deficiency/ Fail results. Verification of testing or repair was not available at the time of survey a) Smoke Detector, 1st floor by medical supply, device not found. b) Fire hat, Maintenance does not have key to reset elevator. c) Primary Recall, Maintenance does not have key to reset elevator. d) Smoke Detector, by house laundry, device not found. e) Shunt trip, Elevator control, not tested.	K 0345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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K 0345 SS=F	Continued from page 5 Exit Interview with the Administrator and Maintenance Director on February 24, 2026, at 2:00 p.m., confirmed the fire alarm deficiencies. ********** ******** Observation during an Onsite Revisit Survey conducted on April 30, 2026, between 11:30 a.m. and 1:15 p.m., revealed the following: Item 1a and item 1d was replaced with a battery-operated smoke detector and was not installed onto the facility fire alarm notification system. All items are not corrected. Exit interview with the Administrator and Maintenance Director on April 30, 2026, at 1:30 p.m., confirmed the above items were not corrected.	K 0345		
K 0351 SS=F		K 0351		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0351 SS=F	Continued from page 6 NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by:	K 0351	Preparation and /or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed with federal and state law requirements. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. Corrective action 1. Plan Review contacted 5/8/26 to acquire appropriate approval for built-in millwork, and for the appropriate means of protection. Cabinet doors removed to ensure compliance. Heat detectors installed 5/18/26 2.Maintenance director or designee to re-educate maintenance staff on the importance of ensuring sprinkler heads or protection by heat detection which activates the fire alarm system are in accordance with	Completion Date: **05/18/2026** Status: **APPROVED** Date: **05/21/2026**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0351 SS=F	Continued from page 7	K 0351	NFPA13 standards 3.Maintenance director or designee to audit built in millwork to ensure Protection by heat detection which activates the fire alarm system Weekly X4 monthlyX2 4.Results will be reviewed at the quarterly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0351 SS=F	Continued from page 8 Based on observation, document review and interview, it was determined the facility failed to provide complete sprinkler coverage, affecting the entire facility. Findings include: 1. Observation made on February 24, 2026, at 12:15 p.m., revealed inside the 1st floor dining room, floor to ceiling millwork cabinetry, with doors, was installed and in use without interior sprinkler coverage. Document review of approved DOH renovation plan H-22-0980 and Sprinkler Plan H-24-1079 shows that all built in millwork was not shown or depicted on plans. Subsequently, DOH Plan Review cannot accurately verify conditions for sprinkler coverage within a fully sprinklered facility. Millwork was installed and in use without DOH life safety occupancy approval for use, during survey. Sprinkler Protection is required by one of the following means: a. Protection by heat detection which activates the fire alarm system.	K 0351		

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K 0351 SS=F	Continued from page 9 b. Protection by automatic sprinkler protection. c. Construction of non-combustible or limited-combustible construction. d. Construction of fire-retardant-treated wood. Exit Interview with the Administrator and Maintenance Director on February 24, 2026, at 2:00 p.m., confirmed the lack of fire protection within the floor to ceiling built-in, closed-door storage cabinetry. ********** Observation during an Onsite Revisit Survey conducted on April 30, 2026, between 11:30 a.m. and 1:15 p.m., revealed the following: Item 1 was not corrected. Exit interview with the Administrator and Maintenance Director on April 30, 2026, at 1:30 p.m., confirmed the above item was not corrected.	K 0351		

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K 0374 SS=E		K 0374		

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K 0374 SS=E	Continued from page 11 NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by:	K 0374	Preparation and /or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed with federal and state law requirements. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. Corrective action 1. Smoke barrier door closures repaired and adjusted to ensure appropriate closure 4/30/26. 2.Maintenance director or designee to re-educate maintenance staff on the importance of maintaining facility smoke barrier doors 3.Maintenance director or designee to audit facility smoke barrier doors to ensure appropriate closure. Weekly X4 monthly X2 4.Maintenance director or designee to audit laundry rooms and medical	Completion Date: **05/18/2026** Status: **APPROVED** Date: **05/20/2026**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0374 SS=E	Continued from page 12	K 0374	supply rooms for smoke detectors weekly X4 monthly X2 5.Results will be reviewed at the quarterly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0374 SS=E	Continued from page 13 Based on observation and interview, it was determined the facility failed to ensure doors in smoke barrier walls were maintained to resist the passage of smoke, affecting one of two levels within the component. Findings include: 1. Observation on February 24, 2026, at the following times revealed: a) 11:35 a.m., The smoke barrier doors (A09) hallway, outside of nurse's station, failed to close smoke tight when tested due to an unsecured door frame within the wall. b) 11:50 a.m., The smoke barrier doors, A- Wing, outside of lobby, failed to swing and close smoke tight due to a broken door closure. Exit Interview with the Administrator and Maintenance Director on February 24, 2026, at 2:00 p.m., confirmed the smoke barrier door deficiencies listed.	K 0374		

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K 0374 SS=E	Continued from page 14 ********** Observation during an Onsite Revisit Survey conducted on April 30, 2026, between 11:30 a.m. and 1:15 p.m., revealed the following: Item 1b was not corrected. Exit interview with the Administrator and Maintenance Director on April 30, 2026, at 1:30 p.m., confirmed the above item was not corrected.	K 0374		

Certified End Page

ACCELA REHAB AND CARE CENTER AT SOMERTON

STATE LICENSE NUMBER: 131602

SURVEY EXIT DATE: 04/30/2026

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

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ACCELA REHAB AND CARE CENTER AT SOMERTON STATE LICENSE NUMBER: **131602**	**650 EDISON AVENUE PHILADELPHIA, PA 19116**

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K 0000	INITIAL COMMENT Facility ID# 131602 Component 02 D Wing Based on a Revisit of a Medicare/Medicaid Recertification Survey completed on February 24, 2026, it was determined that Accela Rehab And Care Center At Somerton - D Wing was not in substantial compliance with the following requirements of the Life Safety Code for an existing Nursing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a one-story, Type II (000), unprotected non-combustible building, that is fully sprinklered.	K 0000		
K 0345 SS=F		K 0345		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395084	A. BLDG: 02 B. WING:	04/30/2026

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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K 0345 SS=F	Continued from page 1 NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by:	K 0345	Preparation and /or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed with federal and state law requirements. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. Corrective action 1. Smoke detectors by medical supply room and laundry room have been replaced and hard wired 5/18/26. Facility retrieved and in possession of fire hat and elevator recall key. Shunt trip, Elevator control, tested 4/13/26. Plan Review Department will be contacted for installation of new fire alarm component. 2. Maintenance director or designee to re-educate maintenance staff on the importance of maintaining smoke	Completion Date: **05/18/2026** Status: **APPROVED** Date: **05/20/2026**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0345 SS=F	Continued from page 2	K 0345	detectors and ensuring elevator testing is maintained. 3.Maintenance director or designee to audit laundry rooms and medical supply rooms for smoke detectors weekly X4 monthly X2 4.Maintenance director or designee to audit elevator inspections weekly X4 monthly X2 5.Results will be reviewed at the quarterly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0345 SS=F	Continued from page 3 Based on observation, document review and interview, it was determined the facility failed to maintain fire alarm system components in operable condition, affecting the entire facility. Findings Include: 1. Documentation reviewed on February 24, 2026, at 9:15 a.m., revealed the fire alarm report dated October 21, 2025, listed devices that were not tested but were also not listed in the Deficiency/ Fail results. Verification of testing or repair was not available at the time of survey a) Smoke Detector, 1st floor by medical supply, device not found. b) Fire hat, Maintenance does not have key to reset elevator. c) Primary Recall, Maintenance does not have key to reset elevator. d) Smoke Detector, by house laundry, device not found. e) Shunt trip, Elevator control, not tested.	K 0345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0345 SS=F	Continued from page 4 Exit Interview with the Administrator and Maintenance Director on February 24, 2026, at 2:00 p.m., confirmed the fire alarm deficiencies. ********** ******** Observation during an Onsite Revisit Survey conducted on April 30, 2026, between 11:30 a.m. and 1:15 p.m., revealed the following: Item 1a and item 1d was replaced with a battery-operated smoke detector and was not installed onto the facility fire alarm notification system. All items are not corrected. Exit interview with the Administrator and Maintenance Director on April 30, 2026, at 1:30 p.m., confirmed the above items were not corrected.	K 0345		

Certified End Page

ACCELA REHAB AND CARE CENTER AT SOMERTON

STATE LICENSE NUMBER: 131602

SURVEY EXIT DATE: 04/30/2026

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY