STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification survey, State Licensure survey, and a Civil Rights Compliance survey completed on December 5, 2024, it was determined that Chestnut Hill Lodge Nursing and Rehabilitation Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0550 SS=D		F 0550		

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:
	395334	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0550 SS=D	Continued from page 1 483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 0550	This plan of correction is submitted to comply with Federal Regulations. This plan is not an admission of guilt, or wrong doing, nor does it-reflect agreement with the facts and conclusions stated in the statement of deficiencies. 1.] Resident's R38 shirt was replaced. Resident R124 belt has been replaced. 2.] All residents are at risk to have their right of dignity violated when clothing labeling is visible on the outside of clothing. 3.] Laundry and Nursing Staff will be educated on proper process of having clothing labeled with emphasis on labeling clothing in a manner that resident names are not visible on the outside of clothing. 4.] Environmental Service Director, or Designee will conduct audits of resident's clothing, weekly x 4 weeks, then monthly x 2 months of all clothing being processed through the laundry to ensure there are no clothes with names of residents visible on the outside of clothing. Results will be reviewed at the	Completion Date: **01/27/2025** Status: **APPROVED** Date: **12/23/2024**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER	**8833 STENTON AVENUE WYNDMOOR, PA 19038**
STATE LICENSE NUMBER: **700102**	

(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
F 0550 SS=D	Continued from page 2 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by:	F 0550	monthly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0550 SS=D	Continued from page 3 Based on observations and interviews with residents, it was determined that the facility failed to maintain or enhance the dignity and respect for two of 33 residents reviewed (Resident R38 and R124). Findings include: During an interview with Resident R38 and R124 on December 4, 2024, at 3:40 p.m. the residents stated that when laundry labels their clothes with their names, they put it in places where it is visible when you are wearing them. Resident R38 stated they put my name on a collar of a shirt, in the front where you can see it when you are wearing it. Resident R124 revealed the jacket she was wearing had a 2-inch belt and on the back of the belt in large letters was the resident's name. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.29 (j)Resident rights	F 0550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER	**8833 STENTON AVENUE WYNDMOOR, PA 19038**
STATE LICENSE NUMBER: **700102**	

(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
F 0636 SS=D		F 0636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0636 SS=D	Continued from page 5 483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning.	F 0636	This plan of correction is submitted to comply with Federal Regulations. This plan is not an admission of guilt, or wrong doing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. - Facility is unable to retroactively correct this deficiency. - An audit was completed to identify all resident's that speak a different language who have been admitted to the facility in the last month, to ensure that the Care Area Assessment reflects that those resident's speak a different language. - Education will be provided to the RNAC to ensure that all residents that speak a different language have it reflected in the Care Area Assessment. - DON/Designee will audit all the Admissions Assessment MDS for all new admissions that speak a different language to make sure that	Completion Date: **01/27/2025** Status: **APPROVED** Date: **12/23/2024**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0636 SS=D	Continued from page 6 (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by:	F 0636	the Care Area Assessment reflects that they speak a different language. Audit will be done weekly x4 weeks and monthly x2 months. Results of these audits will be reviewed at the Quality Assurance Meeting to determine if further action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0636 SS=D	Continued from page 7 Based on observation, clinical record review and interview with staff, it was determined that the facility did not ensure that a comprehensive assessment was completed accurately related to language and communication for one of 33 records reviewed (R417). Findings include: Review of clinical documentation revealed that Resident R417 was admitted to the facility on November 13, 2024, with diagnoses of traumatic subdural hemorrhage (brain bleed caused by injury, which can damage the brain and result in lack of normal functioning), cerebral infarction (death of an area of brain tissue), and dementia (a degenerative neurological condition which results in impaired memory and judgement). Progress notes for the resident revealed that she was on "comfort care," a protocol intended to keep a resident comfortable during end of life, but which is not hospice care.	F 0636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER	**8833 STENTON AVENUE WYNDMOOR, PA 19038**
STATE LICENSE NUMBER: **700102**	

(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
F 0636 SS=D	Continued from page 8 Continued review of the documentation revealed that a Brief Interview for Mental Status (BIMS) assessment was completed for the resident on November 14, 2024. The resident scored a ten out of a possible 15, which indicated moderate impairment of cognitive function. This assessment also included a section titled "Health literacy/Social isolation/Transportation/ Ethnicity/Race", in which it was stated that the resident's preferred language was Vietnamese. Review of Resident R417's Admission Assessment MDS, dated November 16, 2024, revealed that in section V, Care Area Assessment, that the area Communication was triggered for review and care planning. Review of the accompanying Care Area Assessment worksheet for Communication revealed that under the triggered area "Expressive communication", "Speaks different language" was not selected. No care plan for communication was found in the clinical record. Review of physician notes dated December 4,	F 0636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0636 SS=D	Continued from page 9 2024, at 11:25 a.m. stated, "Pt is confused per interpreter service." A "Clinical Nurses Note", dated December 1, 2024, at 10:35 p.m., stated, "Resident is unable to make needs known". Observations conducted on December 2, 2024, at 11:30 a.m. revealed that the resident was unable to speak with the surveyor in English and was responding in short words in another language, which the surveyor did not speak. Interview with Employee E1, the Nursing Home Administrator, and Employee E2, the Director of Nursing, on December 5, 2024, at 2:30 p.m. confirmed that Resident R417 communicated primarily in Vietnamese, and that it should have been reflected in the Care Area Assessment that the resident spoke a different language. 28 Pa Code 211.12 (d)(1) Nursing services	F 0636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0655 SS=D		F 0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0655 SS=D	Continued from page 11 483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:	F 0655	This plan of correction is submitted to comply with Federal Regulations. This plan is not an admission of guilt, or wrong doing, nor does it-reflect agreement with the facts and conclusions stated in the statement of deficiencies. - Residents' R417 and R158 Baseline care plans were updated to reflect a different language spoken other than English. - An audit was completed for all residents that communicate in a language other than English to ensure that their baseline care plans are complete. - Nursing staff will be educated to ensure that baseline care plans are initiated within 48 hours of admission - DON/Designee will audit all new admissions to make sure that residents that do not communicate with English being their primary language have a baseline care plan established. Audits will be done weekly x4 weeks and monthly x2 months. Results of these audits will be reviewed at the Quality	Completion Date: **01/27/2025** Status: **APPROVED** Date: **12/23/2024**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0655 SS=D	Continued from page 12 (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by:	F 0655	Assurance Meeting to determine if further action is needed. Wired jaw - Resident's R315 baseline care plan was updated to include removing the wires from the jaw in an emergency. - No other residents were affected. - Nursing staff will be educated to ensure that baseline care plans for any residents with a wired jaw are developed within 48hrs of admission to the facility. - DON/Designee will audit all new admissions to make sure that residents with a wired jaw have a plan of care developed to include removing the wires from the jaw in an emergency. Audits will be done weekly x4 weeks and monthly x2 months. Results of these audits will be reviewed at the Quality Assurance Meeting to determine if further action is needed. Bipolar and suicidal ideation. - Resident R420's care plan was developed to reflect his specific health needs related to suicidal ideation and bipolar disorder. - An audit of all residents with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER	**8833 STENTON AVENUE WYNDMOOR, PA 19038**
STATE LICENSE NUMBER: **700102**	

(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
F 0655 SS=D	Continued from page 13	F 0655	diagnosis of Bipolar Disorder and suicidal ideation was completed to ensure that they had care plans developed related mental health needs related to suicidal ideation and bipolar disorder. - Nursing staff will be educated to ensure that care plans are developed for all residents with bipolar disorder and suicidal ideations. - DON/Designee will audit all new admissions to make sure that residents that have a diagnosis of bipolar disorder or suicidal ideation have a care plan developed. Audits will be done weekly x4 weeks and monthly x2 months. Results of these audits will be reviewed at the Quality Assurance Meeting to determine if further action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: 700102	8833 STENTON AVENUE WYNDMOOR, PA 19038

(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
F 0655 SS=D	Continued from page 14 Based on observation, clinical record review and interview with staff and residents and review of facility policy, it was determined that the facility did not develop a person-centered baseline care plan within 48 hours of a resident's admission related to language and communication for two residents, for a surgically wired jaw for one resident, and mental healthcare needs for one resident of 33 residents reviewed (Resident R158, R315, R417, R420). Findings include: Review of facility policy, "Care Planning Process and Care Conference," revised July 3, 2023, revealed: "Staff shall interact with the residents in a way that accomodates the physical or sensory limitations of the residents, promotes communication and maintains dignity. The facility's language access program will ensure that individuals with limited	F 0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0655 SS=D	Continued from page 15 English proficiency (LEP) shall have meaningful access to information and services provided by the facility. When encountering LEP individuals, staff members will conduct the initial language assessment and notify the staff person in charge of the language access program. The coordinator of the facility's language access program. The coordinator of the the facility's language access program is the Director of Social Services, or his/her designee as determined by the NHA. It is understood that providing meaningful access to services provided by the facility requires also that the LEP resident's needs and questions are accurately communicated to the staff. Oral Interpretation Services therefore include interpretation from The LEP resident's primary language back to English. Care plans should reflect the LEP services utilized and specific activity programs that are provided to the resident based on their preferences. Activity programs are designed to meet the interests of and support the physical, mental and psycho-social well beingof each resident as well as, encouraging both independence and community iinteraction.	F 0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0655 SS=D	Continued from page 16 An interdisciplinary baseline care plan will be initiated upon admission by the admitting nurse and completed within 48 hours. A copy of the baseline care plan will be reviewed with and provided to the resident/patient and/or resident representative, upon admission (within 48 hours). Facility will maintain evidence that the baseline care plan was provided (ex: nursing enters an admission progress note indicating "resident admitted, assessments completed, introduced to surroundings and a copy of the baseline care plan was reviewed with resident and left at the bedside. RP called to notify of resident's arrival and baseline care plan was reviewed with RP). Include such initial needs/problems such as ADL's, falls, skin tears, risk for skin breakdown, nutritional status, behaviors, pacemaker, anticoagulants, psychotropic medication use, etc. Include a care plan related to the resident's primary diagnosis." Resident R158 was admitted to the facility on November 13, 2024 with the following diagnoses:	F 0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0655 SS=D	Continued from page 17 encephalopathy (brain disease that alters brain function or structure); severe protein calorie malnutrition (critical condition where a personis severelydeficient in both protein and calories, leading to significant muscle wasting, loss body fat, and impaired immune function. Diabetes Mellitis type II (condition in which body has trouble controlling blood sugar and using it for energy.) and cerebral infarction due to embolism an ischemic stroke). Review of Resident R158's MDS (Federally mandated resident assessment and care screening) dated November 13, 2024, revealed that English is the primary language of Resident R158. Review of Resident R158"s baseline care plan revealed no evidence of language barrier or communication challenges related to English as a second language and Vietnamese as the primary language. Resident R158's care plan did not reflect the LEP services utilized and specific activity programs that are provided to Resident R158 based	F 0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: 700102	8833 STENTON AVENUE WYNDMOOR, PA 19038

(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
F 0655 SS=D	Continued from page 18 on her preferences. Interview on December 3, 2024 at 10:42 a.m. with Employee E3, unit manager, revealed that Resident 158 "understands some English and speaks Vietnamese. We have consistent staffing here and the resident has a good rapport with her nurse aide. For almost all of our residents (on the memory care unit). we anticipate their needs. We have used the interpreter hotline at times, but not often. Usually we can anticipate her needs." Employee E13, Resident R158's nurse aide was unavailable for interview. Resident R158 was unable to participate in an interview with surveyor. Interview with Employee E1, the Nursing Home Administrator, and Employee E2, the Director of Nursing, on December 5, 2024, at 2:30 p.m. confirmed that Residenst R417 and R158 communicated primarily in Vietnamese, and that it	F 0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0655 SS=D	Continued from page 19 should have been reflected in the Care Area Assessment that the resident spoke a different language. Review of Resident R315's Admissions Minimum Data Set dated November 20. 2024, revealed the resident was alert and oriented, able to make needs know, diagnosed with multiple fractures, and impaired to both sides of her upper and lower body. Nursing note dated November 14, 2024, stated Resident R315 was a pedestrian in a motor vehicle accident and sustain multiple fractures and lacerations to her internal organs. The resident's jaw was wired closed and was ordered a clear liquid diet instructing to be fed with a syringe and a staff member present at all times with meals. Review of Resident 315's care plan revealed the resident was at risk of aspiration and instructed to monitor for signs and symptoms of aspiration. Further review of the care plan failed to develop a plan of care to include removing the wires from the jaw in an emergency.	F 0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: 700102	8833 STENTON AVENUE WYNDMOOR, PA 19038

(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
F 0655 SS=D	Continued from page 20 Interview with the Director of Nursing indicated pliers were available at the resident's bedside in case the wires needed to be removed but confirmed the intervention was not included in the resident's plan of care. Review of clinical documentation revealed that Resident R417 was admitted to the facility on November 13, 2024, with diagnoses of traumatic subdural hemorrhage (brain bleed caused by injury, which can damage the brain and result in lack of normal functioning), cerebral infarction (death of an area of brain tissue), and dementia (a degenerative neurological condition which results in impaired memory and judgement). Progress notes for the resident revealed that she was on "comfort care," (a protocol intended to keep a resident comfortable during end of life, but which is not hospice care). Review of Resident R417's MDS completed November 14, 2024, indicated a Brief Interview for Mental Status (BIMS) assessment with a score of	F 0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0655 SS=D	Continued from page 21 ten -moderate impairment of cognitive function. This assessment also included a section titled "Health literacy/Social isolation/Transportation/ Ethnicity/Race" in which it was stated that the resident's preferred language was Vietnamese. Review of resident R417's Admission Assessment MDS, dated November 16, 2024, revealed that in section V, Care Area Assessment, that the area Communication was triggered for review and care planning. No care plan for communication was found in the clinical record. Review of physician notes dated December 4, 2024, at 11:25 a.m. stated, "Pt (patient) is confused per interpreter service." A "Clinical Nurses Note", dated December 1, 2024, at 10:35 p.m., stated, "Resident is unable to make needs known". Observations conducted on December 2, 2024, at 11:30 a.m. revealed that the resident was unable to speak with the surveyor in English and was responding in short words in another language,	F 0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0655 SS=D	Continued from page 22 which the surveyor did not speak. Interview with Employee E1, the Nursing Home Administrator, and E2, the Director of Nursing, on December 5, 2024, at 2:30 p.m. confirmed that Resident R417 communicated primarily in Vietnamese, and that a baseline care plan for communication should have been developed and was not. Review of documentation for Resident R420 revealed that he was admitted to the facility with diagnoses,of suicidal ideations, and bipolar disorder (a mental health condition consisting of extreme highs and lows in mood and affect, which can impact decision making and behaviors). Review of the care plan for the resident revealed that no care plan was developed related to his specific mental health needs related to suicidal ideation and bipolar disorder. Observation of Resident R420 on December 3,	F 0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0655 SS=D	Continued from page 23 2024, at 1:03 p.m. revealed that the resident had a flat affect and appeared withdrawn. Interview with Employee E1, the Nursing Home Administrator, and Employee E2, the Director of Nursing, on December 5, 2024, at 2:30 p.m. confirmed that a baseline care plan for the specific mental health needs should have been developed and was not. 28 Pa. Code 211.5(f)(viii) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0655		
F 0656 SS=D		F 0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: 700102	8833 STENTON AVENUE WYNDMOOR, PA 19038

(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
F 0656 SS=D	Continued from page 24 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	This plan of correction is submitted to comply with Federal Regulations. This plan is not an admission of guilt, or wrong doing, nor does it-reflect agreement with the facts and conclusions stated in the statement of deficiencies. - Resident's R314 care plan was developed to address needs related to a diagnosis of Anemia. - An audit of all residents with a diagnosis of Anemia was completed to ensure there are care plans present to address needs related to Anemia. - Education will be done for Nursing staff to ensure that residents with a diagnosis of Anemia have care plans developed. - DON/Designee will audit the charts of all new admissions and any residents with a new diagnosis of Anemia to ensure they have comprehensive care plans developed. Audits will be done weekly x4 weeks and monthly x2 months. Results of these audits will be reviewed at the Quality Assurance Meeting to determine if	Completion Date: **01/27/2025** Status: **APPROVED** Date: **12/23/2024**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0656 SS=D	Continued from page 25 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656	further action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0656 SS=D	Continued from page 26 Based on observations, review of facility policy, review of clinical records, and interview with resident and staff, it was determined that the facility failed to develop and implement comprehensive, person-centered care plans to address resident care needs related to a diagnosis of anemia and psychotropic medications for one of 33 resident records reviewed (Resident R314). Findings include: Resident R314 was admitted to the facility on November 13, 2024, diagnosed with anemia (not enough healthy red blood cells resulting in a reduced ability of the blood to carry oxygen to the body). Review of Resident R314's physician note, dated November 20, 2024, referenced the resident's critical hematology report dated November 15, 2024. The same note stated to monitor Resident R314's hematocrit (present of red blood cells in the blood) and hemoglobin (Hgb transports oxygen and carbon dioxide) relating to the resident's diagnosis of	F 0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0656 SS=D	Continued from page 27 anemia and stated to consider "Transfer for (blood) transfusion if Hg drops <7.0, and to monitor for signs and symptoms of fatigue, impact on therapy, monitor for oxygen use, check pulse ox as needed prior to and during therapy." Further review of Resident R314's clinical record revealed the facility failed to develop a care plan for the resident's diagnosis of anemia. 8 Pa. Code 211.10 (d) Resident care policies. 28 Pa. Code 211.12 (d)(3) Nursing services. 28 Pa. Code 211.12 (d)(5) Nursing services.	F 0656		
F 0657 SS=D		F 0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0657 SS=D	Continued from page 28 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	This plan of correction is submitted to comply with Federal Regulations. This plan is not an admission of guilt, or wrong doing, nor does it-reflect agreement with the facts and conclusions stated in the statement of deficiencies. - Resident's R63 care plan was revised to reflect the current goal and interventions with ordered diet. - An audit of all residents with enteral feeds was completed to ensure that goals and interventions with ordered diets were reflected on their current care plans. - Nursing staff and Dietician will be educated to ensure that care plans are revised timely with any diet changes. - DON/Designee will audit for any residents that have had their enteral feeds discontinued to ensure that care plans have been updated. Audits will be done weekly x4 weeks and monthly x2 months. Results of these audits will be reviewed at the Quality Assurance Meeting to determine if further action is needed.	Completion Date: **01/27/2025** Status: **APPROVED** Date: **12/23/2024**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0657 SS=D	Continued from page 29 Based on observations, clinical record review, review of facility documents and staff interviews, it was determined that the facility failed to revise the care plan for tube feeding management, for one of 33 residents reviewed (Resident R63). Findings include: Review of Resident R63's clinical record revealed that the resident was admitted in the facility on February 12, 2024. Resident R32's diagnoses included Protein Calorie Malnutrition (condition synonymous with starvation, resulting when the body's needs for protein, energy, or both cannot be met by diet), and Oropharyngeal Phase Dysphagia (swallowing problems occurring in the mouth and/or the throat. These swallowing problems most commonly result from impaired muscle function, sensory changes, or growths and obstructions in the mouth or throat). Review of physician order for Resident R63, dated April 1, 2024, indicated an order to cleanse area	F 0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0657 SS=D	Continued from page 30 around feeding tube with soap and water and gently pat dry, daily and as needed; clean, dry drain sponge may be placed if needed; every day- shift and as needed. Review of physician order for Resident R63, dated July 22, 2024, indicated an order for Controlled Carb/Renal Diet: Mechanical Soft Texture, Thin consistency. On December 2, 2024, at 12:34 p.m., review of the care plan of R63, revealed that it was not updated, or revised, to reflect the goal and interventions with the ordered diet and peg tube site care. At the time of the findings, interview with the charge nurse, a Registered Nurse, Employee E6, confirmed the same. 28 Pa. Code 211.12(d)(1) Nursing services	F 0657		
F 0677 SS=E		F 0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0677 SS=E	Continued from page 31 483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 0677	This plan of correction is submitted to comply with Federal Regulations. This plan is not an admission of guilt, or wrong doing, nor does it-reflect agreement with the facts and conclusions stated in the statement of deficiencies. - Resident's R315 Physician orders were clarified to reflect restrictions for showering. - An audit was completed to identify if there were any residents that had restrictions for showers to ensure appropriate documentation was in place. - Nursing staff will be educated on obtaining Physician orders and ensuring appropriate documentation is in the resident clinical record if any resident has restrictions for showers. - DON/Designee will audit all new admissions/readmissions to make sure that Physician orders are obtained for any residents with showering restrictions. Audits will be done weekly x4 weeks and monthly x2 months. Results of these audits will be reviewed at the Quality	Completion Date: **01/27/2025** Status: **APPROVED** Date: **12/23/2024**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0677 SS=E	Continued from page 32	F 0677	Assurance Meeting to determine if further action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0677 SS=E	Continued from page 33 Based on observation, staff and resident interviews, and review of clinical records, it was determined the facility failed to provide the necessary services to maintain adequate grooming and hygiene for one of 33 sampled residents (Resident R315). Findings include: Review of Resident R315's Admissions Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated November 20. 2024, revealed the resident was alert and oriented, able to make needs know, and diagnosed with fractures and malnutrition, with impairments to both sides of her upper and lower body. The same MDS indicated the resident was dependent on staff for all activities of daily needs and when asked it was very important for the resident to choose between a tub bath, shower, bed bath or sponge bath. Interview with Resident R315 on December 4, 2024, at 11:00 a.m. stated that she was never	F 0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0677 SS=E	Continued from page 34 offered a shower since she's been at the facility. "I only get bed bath and I would really like a shower." Interview with Resident R351's Nursing Aide, Employee E3 on December 4, 2024, at 11:20 a.m. confirmed the staff only gives her bed baths because it might be too much for the resident. Review of Resident 351's physician orders revealed the resident's "shower/bath" days were every Tuesday and Friday and care planned for needing one staff member to assist with "bathing/showering". Further review of the resident's clinical records did not reveal restrictions for showering. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER	**8833 STENTON AVENUE WYNDMOOR, PA 19038**
STATE LICENSE NUMBER: **700102**	

(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
F 0684 SS=D		F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0684 SS=D	Continued from page 36 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	This plan of correction is submitted to comply with Federal Regulations. This plan is not an admission of guilt, or wrong doing, nor does it-reflect agreement with the facts and conclusions stated in the statement of deficiencies. Appointments: - Appointments for Resident R16 were scheduled for both ENT and Neurology. - An audit of Physician progress notes and physician recommendations for the past 2 weeks were completed to ensure that appropriate follow through was made for any follow up appointments ordered by the Provider. - Education will be provided to Nursing staff to ensure that all Physician recommendations requesting consultation follow up are followed through with. - DON/Designee will audit Physician recommendations to ensure appointments are made as recommended. Audits will be done weekly x4 weeks and monthly x2	Completion Date: **01/27/2025** Status: **APPROVED** Date: **12/23/2024**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0684 SS=D	Continued from page 37	F 0684	months. Results of these audits will be reviewed at the Quality Assurance Meeting to determine if further action is needed. Medication Left Bedside: - Medication for Resident R315 was removed from the bedside. - All rooms were checked to make sure there were no medications at the resident's bed side. - Education will be provided to nursing staff to ensure that completed/discontinued medications are disposed of per facility protocol. - DON/Designee will complete random audits to ensure that medications that have been completed or discontinued are disposed of per facility protocol. Audits will be done weekly x4 weeks and monthly x2 months. Results of these audits will be reviewed at the Quality Assurance Meeting to determine if further action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0684 SS=D	Continued from page 38 Based on observations of care and services, review of clinical record and review of facility policy and interviews with staff and residents, it was determined that the nursing staff failed to obtain and schedule examinations with a specialist as indicated by the physician and to ensure that a medication was administered during the time period prescribed by the physician for two of 47 residents reviewed. (Resident R16 and Resident R315) Findings include: A review of the facility policy titled verbal and telephone physician's orders dated May, 2024 revealed that it was the policy of the facility to secure physican's orders for the care and services for the residents. The physician's orders for care and services were required to be dated and signed accordingly and entered into the resident's medical record. The policy also indicated that an order for medical	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0684 SS=D	Continued from page 39 or therapeutic measures and medications or treatments were to be given to a registered or licensed nurse. The registered or licensed nurse were required to obtain a medical diagnosis or reason from the physician for the care, treatment or medication being used for the residents. The policy also said that any unclear or incomplete physician's orders for care, treatment or medications were to be clarified by the registered or licensed nurse. The policy indicated that it was the responsibility of the registered or licensed nurse to verify with the physician any pending consultation or specialist appointments and recommendations or results of testing completed by a specialists. Observations of Resident R16 at 10:30 a.m. on December 2, 2024 with Licensed nurse, Employee E4 revealed that the resident was reporting that she preferred to lay in a supine position because she was dizzy sitting up or moving side to side. The licensed nurse, Employee E4 reported at 11:00 a.m., on December 2, 2024 that Resident R16 had	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0684 SS=D	Continued from page 40 a diagnosis of vertigo (a sudden internal or external spinning sensation often triggered by moving the head). Clinical record review revealed a quarterly comprehensive assessment (MDS- an assessment of care needs) dated October 31, 2024 for Resident R16 indicated that this resident was cognitively intact and had a diagnosis of cerebral palsy (a movement disorder affecting muscle tone, lack of balance and muscle coordination with stiff or floppy muscle characteristics). Interview with Resident R16 at 10:45 a.m., on December 2, 2024 revealed that the resident has not been sitting up very long or getting out of bed into a chair; because of her dizziness. The resident also reported that an orthotic device for her neck or head was not used as adapted equipment for her symptoms of dizziness. Clinical record review revealed that on April 30, 2024, the nurse practitioner assessed and	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0684 SS=D	Continued from page 41 documented that the nursing staff were to administer Resident R16 Meclizine (a medication for motion sickness and vertigo) 12.5 milligrams as needed for vertigo. Clinical record review revealed the care planned by the nurse practitioner on April 30, 2024 was for the registered or licensed nursing staff to schedule an ear, nose and throat specialist examination for Resident R16 to evaluate the vertigo. Also for the resident to be evaluated by a neurologist to determine the causes of the vertigo symptoms. Continue review of Resident R16's clinical notes dated April 30, 2024 revealed for nursing and physical therapy staff, to continue with active range of motion and passive range of motion exercises twice a day for Resident R16. Interview with the licensed practical nurse, Employee E4 and the licensed occupational therapist, Employee E6 at 10:00 a.m., on December 3, 2024 confirmed that there was no ENT (ear,	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0684 SS=D	Continued from page 42 nose or throat) specialist examination ordered or completed for Resident R16. Further interview with the licensed nurse and licensed occupational therapist on December 3, 2024 confirmed that there was no physican's order obtained on April 30, 2024, for Resident R16 to be examined by a neurologist to determine the possible cause of her symptoms of frequent dizziness. The lack of obtaining physician's orders by the licensed nursing staff for consultations with the ENT specialist and the neurologist (a physician who was trained in diagnosing and treating diseases of the brain, spinal cord and nerves) was confirmed by the Director of Nursing at 1:00 p.m., on December 4, 2024. Review of the facility policy "Medication Administration" revised September 2023 states, "Medications, both prescription and non-prescription shall be administered under the orders of the attending physician."	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0684 SS=D	Continued from page 43 Review of Resident R315's clinical records revealed the resident was admitted on November 14, 2024, diagnosed with multiple fractures and lacerations to her internal organs from a motor vehicle accident. During an interview with Resident R315 on December 4, 2024, at 10:30 a.m. the surveyor observed a bottle of of Chlorhexidine Gluconate (an oral antimicrobial) next to the resident, sitting on the tray table. The resident indicated that she uses the mouth rinse after meals. Review of Resident 315's physician orders revealed Chlorhexidine Gluconate was initially ordered for fourteen days on November 14, 2024, and was discontinued on November 28, 2024. The above was confirmed with the Director of Nursing on December 4, 2024, at 1:30 p. that the oral rinse was discontinued. 28 PA. Code 211.12(d)(1)(2)(3)(5) Nursing services	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0684 SS=D	Continued from page 44 28 PA. Code 211.10(a)(c)(d) Resident care policies 28 PA. Code 211.5(f)(i)(ii)(iii)(vii)(viii)(ix) Medical records	F 0684		
F 0759 SS=D		F 0759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0759 SS=D	Continued from page 45 483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by:	F 0759	This plan of correction is submitted to comply with Federal Regulations. This plan is not an admission of guilt, or wrong doing, nor does it- reflect agreement with the facts and conclusions stated in the statement of deficiencies. - Facility is unable to retroactively correct this deficient practice. - All residents residing in the facility are at risk of being affected. - Education for nursing staff will be completed to ensure that nurses administer the correct medications during medication passes. - DON/Designee will complete random medication pass competencies to ensure facility is free of medication errors. Audits will be done weekly by 4 weeks and monthly x2 months. Results of these audits will be reviewed at the Quality Assurance Meeting to determine if further action is needed.	Completion Date: **01/27/2025** Status: **APPROVED** Date: **12/23/2024**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0759 SS=D	Continued from page 46 Based on observations, review of clinical records, and interviews with facility staff, it was determined that the facility failed to ensure that it was free of medication error rate of five percent or greater for two of four residents observed during medication administration (Residents R4, and R77). Findings include: On December 3, 2024, 9:39 a.m., observed that Employee E7, a Registered Nurse, administered to Resident R77, the medicine, Aspirin 81 mg, chewable tablet, one tablet by mouth; when asked the Licensed Nurse to double check the medicine, the nurse stated it was Aspirin 81 mg, chewable tablet. Review of physician order for Resident R77, revealed an order, dated September 28, 2020, to administer Aspirin Enteric-Coated (EC) Tablet Delayed Release 81 MG (Aspirin), give 1 tablet by mouth one time a day.	F 0759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0759 SS=D	Continued from page 47 Review of literature revealed that Aspirin comes in enteric-coated and non-enteric (regular) forms. Regular Aspirin is absorbed in the stomach, while Enteric-Coated aspirin is absorbed in the small intestine. At the time of the observation, interview with Registered Nurse, Employee E7, confirmed the above findings. On December 3, 2024, 9:49 a.m., observed that Employee E7, administered to Resident R4, the medicine, Aspirin 81 mg, chewable tablet, one tablet by mouth; when asked Registered Nurse, Employee E7 to double check the medicine, the nurse stated it was Aspirin 81 mg, Chewable tablet. Review of physician order for Resident R4, revealed an order, dated August 18, 2023, to administer Aspirin Enteric-Coated (EC) Tablet Delayed Release 81 MG (Aspirin), Give 1 tablet by mouth in the morning for CVA (Cerebrovascular Accident, which is the medical term for a stroke).	F 0759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0759 SS=D	Continued from page 48 At the time of the observation, interview with Registered Nurse, Employee E7, confirmed the above findings. The facility incurred a medication error rate of 5.7%. Pa Code:211.12(d)(1)(2)(5) Nursing Services.	F 0759		
F 0925 SS=E		F 0925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0925 SS=E	Continued from page 49 483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by:	F 0925	This plan of correction is submitted to comply with Federal Regulations. This plan is not an admission of guilt, or wrong doing, nor does it- reflect agreement with the facts and conclusions stated in the statement of deficiencies. 1.] All items identified as deficient in the kitchen have been cleaned, repaired or replaced. 2.] An Initial Audit will be conducted in the Kitchen to identify other items that might be in need of cleaning, repair or replacement. 3.] Food Service will be educated on proper cleaning, maintenance and repair procedures for the kitchen and its equipment. 4.] Food Service Director will conduct audits, weekly x 4 weeks, then monthly x 2 month in the facility kitchen to ensure the kitchen is being cleaned and maintained. Results will be reviewed at monthly QAPI.	Completion Date: **01/27/2025** Status: **APPROVED** Date: **12/23/2024**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0925 SS=E	Continued from page 50 Based on observations of the food and nutrition services department, interviews with staff, reviews of policies and procedures and the pest control operator's reports, it was determined that the main kitchen was not maintained and operated to ensure an effective pest control program. Findings include: Review of the policy titled kitchen cleaning dated December, 2024 revealed that it was the responsibility of the dietary staff to ensure that the main kitchen was clean and sanitary by adhering to a comprehensive cleaning schedule throughout the food and nutrition department. Observations of the main kitchen in the presence of the director of dietary, Employee E5, at 9:30 a.m., on December 2, 2024 revealed the following: The plumbing in the dish room area was not draining properly. Soiled water and food waste was over flowing onto the floor in the this section of the main	F 0925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0925 SS=E	Continued from page 51 kitchen. A dietary staff member was using a hand held plunger to try to unclog the sink that was adjacent to the dish machine. The flooring throughout the dish room area contained a covering of a white substance resembling lime deposits. The dish machine, work tables and racks that were connected to the dish machine contained a white powdery film that resembled hard water and calcium deposit residue. The ceiling tiles in the dish room area contained water damage. The ceiling tiles were brown stained and warped. The ceiling light fixture screens above the dish machine, contained a collection of dead insects. The wall area and ceiling tiles contained dried food debris. The grouting was missing between the floor tiles in the dish room. The missing grouting provided food for common household pests to breed and live. The disrepair in the flooring was porous and not easily cleanable. There was an accummulation of dirt,	F 0925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0925 SS=E	Continued from page 52 food debris and moisture in the gaps on the flooring. The entire perimeter of the flooring and cove molding in the dishroom contained a build-up of dirt and discarded food particles. The ceiling tiles and light screen covering above the hot food preparation area that was adjacent to the hood situated directly above the hot food equipment and cooking, contained a heavy accumulation of grease, dust and food splattering. An industrial sized piece of food service equipment located in the hot food preparation area, called a braise or tilt skillet was not functioning for several months. It contained a build of grease, food debris and dust. The perimeter of the flooring in the dry food storage area contained an accumulation of streaking and smudging along the perimeter of the flooring and walls with patches of mice droppings. The ceiling light screens located in the dry food	F 0925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0925 SS=E	Continued from page 53 storage area were brown stained with water damage. The ceiling light screens also contained a large number of dead roaches. The working mechanisms underneath the three compartment sink were not holding water regularly and a catch pan was placed below the piping to capture the leaking water. The pest control operator's reports were reviewed for September, October and November, 2024 and revealed that the main kitchen of the food and nutrition department was targeted for common household pests (roaches and mice). The pest control operator was used various treatments and traps to combat the invaders. 28 PA. Code 201.14(a) Responsibility of licensee 28 PA. Code 201.18(b)(1)(3)(e)(1)(2.1) Management 28 PA. Code 205.13(b) Floors	F 0925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395334	A. BLDG: __00_____ B. WING: _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER STATE LICENSE NUMBER: **700102**	**8833 STENTON AVENUE WYNDMOOR, PA 19038**

(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
F 0925 SS=E	Continued from page 54	F 0925		

Certified End Page

CHESTNUT HILL LODGE HEALTH AND REHABILITATION CENTER

STATE LICENSE NUMBER: 700102

SURVEY EXIT DATE: 12/05/2024

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