STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395627	A. BLDG: 00 B. WING:	08/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
FAIRLANE GARDENS NURSING AND REHAB AT READING STATE LICENSE NUMBER: **026202**	**21 FAIRLANE RD** **READING, PA 19606**

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F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification survey, State Licensure survey, and a Civil Rights Compliance survey completed on August 14, 2025, it was determined that Fairlane Gardens Nursing and Rehabilitation at Reading 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 0584 SS=E		F 0584		

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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F 0584 SS=E	Continued from page 1 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	- Splatter on floors, ceilings and walls were cleaned - Radiator in unit 2 lounge will be repaired - Mirrors will be replaced in rooms 217; 224; 308; 309; 310- - Exterminator to be in to the flying winged insects? - The wall in room 300 was repaired - Shower room curtains cleaned, odor free; shower chair replaced - non Skid mat in 3rd shower room cleaned Cleaning schedule will be put into place, to include resident rooms and shower room. Floor care will be placed on a routine schedule. All housekeeping and Maintenance will be re-educated on cleaning of the facility Audits will be completed by the IDT team daily x4 weeks then weekly x4; then monthly x2 with results to be reported to the QAPI committee.	Completion Date: **09/23/2025** Status: **APPROVED** Date: **08/26/2025**

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F 0584 SS=E	Continued from page 2 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584		

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F 0584 SS=E	Continued from page 3 Based on observation, it was determined that the facility failed to provide a safe, clean, and comfortable environment on four of four nursing units. (1A, 1B, 2A, 2B) Findings include: Observations on August 12, 2025, from 9:00 a.m. through 12:17 p.m. revealed the following: Debris and a dark/black substance splattered throughout the hall floors of Units 1A, 1B, 2A, and 2B and rooms 101, 109, 110, and 115. The floor in 217 had red and brown spots between the beds. There were brown spots on the ceiling in the hallway at room 227. There were red spots on the wall by the door in room 310.	F 0584		

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F 0584 SS=E	Continued from page 4 The radiator in the resident lounge was broken with sharp, loose parts lying on the floor. The wall by the left entrance door in the main dining room was damaged. The wall behind both beds in room 308 was damaged. The ceiling and wall behind the toilet in room 308 were damaged. The mirrors were damaged in the bathrooms in rooms 217, 224, 308, 309, and 310. There were flying winged insects noted around the nurse's station of section 1A and in room 300. Observations on August 13, 2025, at 9:15 a.m. through 11:31 a.m., revealed the following: A strip of peeling wood sticking out of the bottom of the closet door for room 205 bed two.	F 0584		

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F 0584 SS=E	Continued from page 5 Debris and a dark/black substance splattered throughout the hall floors of Unit 1A and rooms 101, 109, 110, and 115. Flying winged insects were noted throughout the hallway in section 1A and in room 300. The wall was damaged by the resident's bed in room 300. Observations in the shower room across from nurse's station intersecting halls 100-300 on August 13, 2025 at 11:30 a.m., revealed: The shower room had a musty smell. A grey and brown residue on the floor tiles in all three shower stalls. A yellow substance on the shower chair in the first stall.	F 0584		

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F 0584 SS=E	Continued from page 6 The non-skid strips in the first and third shower stalls were worn. A residue on all three shower curtains. All three shower curtains were missing hooks. A black substance on the non-skid mat in the third shower stall. A brown and red substance on the floor in front of the scale. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management.	F 0584		
F 0641 SS=D		F 0641		

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F 0641 SS=D	Continued from page 7 483.20(g)(h)(i)(j) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement.	F 0641	- Resident 27s; MDS was modified to indicate the use of an anti-psychotic medication during the seven-day review period - Resident 18s MDS was modified to reflect tracheostomy care received during the seven days look back period - MDS of current residents on anti-psychotic medications and residents with tracheostomy care within the past 90 days were reviewed for accuracy MDS coordinators were re-educated on accuracy of MDS. Random audits will be completed by NHA/ Designee on the accuracy of the MDS of the residents who are currently on antipsychotic medications and tracheostomy care. Weekly x4 Monthly x2 with results to QAPI committee	Completion Date: **09/23/2025** Status: **APPROVED** Date: **08/26/2025**

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F 0641 SS=D	Continued from page 8 This REQUIREMENT is not met as evidenced by:	F 0641		

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F 0641 SS=D	Continued from page 9 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the Minimum Data Set (MDS) assessment was completed to accurately reflect the residents status for two of 24 sampled residents. (Residents 27, 78) Findings include: Clinical record review revealed that Section N (Medications) of Resident 27's MDS assessment dated June 18, 2025, indicated that the resident was not on an antipsychotic medication during the seven-day review period. Review of the resident's Medication Administration Record from June 2025 revealed that the resident did receive an antipsychotic (lurasidone) during the seven-day review period. Clinical record review revealed that section O (Special treatments, procedures, and programs) of the MDS assessment dated July 15, 2025, indicated that Resident 78 did not receive tracheostomy care during the seven-day review period. Review of	F 0641		

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F 0641 SS=D	Continued from page 10 Resident 21s Treatment Administration record from July 2025 revealed that the resident did receive tracheostomy care during the seven-day review period. In an interview on August 13, 2024, at 2:26 p.m., Registered Nurse Assessment Coordinator 1 confirmed the MDS assessments had not accurately reflected the residents' status and had to be modified by the facility. CFR 483.20(g) Accuracy of Assessments. Previously cited 7/12/24	F 0641		
F 0684 SS=E		F 0684		

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F 0684 SS=E	Continued from page 11 483.25 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	Unable to correct past events Current residents' medication and weight orders reviewed for proper evidence of documentation of residents BP, HR., and weights Current licensed staff re-educated on medication administration policy and procedure, weight policy and procedure. Alng with Documentation Policy and procedure . - Random audits to be completed by DON/ designee to ensure appropriate documentation of resident heart rate, and bp prior to medication administration and appropriate weight documentaion. Weekly x4; Monthly x2 , with results to QAPI committee	Completion Date: **09/23/2025** Status: **APPROVED** Date: **08/26/2025**

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F 0684 SS=E	Continued from page 12 Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to administer medications in accordance with physician orders for four of 24 sampled residents. (Residents 2, 6, 19, 34) Findings include: Review of the policy entitled, "Medication Administration," last reviewed July 14, 2025, revealed staff were to obtain vital signs if necessary, and document physician indicated medication administration information. Clinical record review revealed that Resident 2 had diagnosis of hypertension (high blood pressure). On April 3, 2025, the physician ordered staff to administer a blood pressure medication (lisinopril) one time a day. The medication was to be held if the resident's systolic blood pressure (SBP, the first measurement of blood pressure when the heart beats and the pressure is at its highest) was less than 110 millimeters of mercury (mm/Hg) or if the	F 0684		

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F 0684 SS=E	Continued from page 13 resident's heart rate (the number of times a heart beats in one minute) was less than 60 bpm (beats per minute). Review of Resident 2's Medication Administration Records (MAR) for May, June, July, and August 2025, revealed that staff administered the medication three times in May, five times in June, and three times in July when the resident's SBP was below 110 mm/Hg. Review of Resident 2's MARs for May and June 2025, revealed no evidence that staff obtained the resident's heart rate prior to administration of the medication on 23 occasions in May 2025, and 16 occasions in June 2025. Clinical record review revealed that Resident 6 had diagnoses that included atrial fibrillation (irregular heartbeat) and hypertension (high blood pressure). On June 5, 2025, the physician ordered staff to administer a blood pressure medication (midodrine) two times a day for orthostatic blood pressure (a drop in blood pressure when changing positions) and to monitor for supine (laying) and sitting blood pressures. Review of Resident 6's care plan revealed an intervention to monitor blood pressure	F 0684		

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F 0684 SS=E	Continued from page 14 as ordered. Physician's notes dated June 6 and June 21, 2025, July 9, 21, and 26, 2025, and August 6, 2025, revealed staff were to continue to monitor the resident's blood pressure. There was no documented evidence that staff monitored Resident 6's blood pressure as ordered by the physician. Clinical record review revealed that Resident 19 had diagnoses that included congestive heart failure and type 2 diabetes. A physician's order dated May 3, 2025, directed staff to weigh the resident daily. Review of Resident 19's MAR for May, June, July, and August 2025, revealed no evidence that the resident's weights were obtained per physician's orders on six occasions in May, three occasions in June, four occasions in July, and three occasions in August 2025. Clinical record review revealed that Resident 34 had diagnoses that included hypertension and chronic kidney disease. On July 30, 2022, the physician ordered staff to administer a blood pressure medicine (metoprolol succinate) one time a day.	F 0684		

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F 0684 SS=E	Continued from page 15 Staff were not to administer the medication if Resident 34's heart rate was less than 60 bpm. Review of Resident 34's MAR for June, July, and August 2025, revealed no evidence that staff obtained the resident's heart rate prior to administration of the medication on 72 occasions. In an interview on August 14, 2025, at 10:10 a.m., the Director of Nursing confirmed that Resident 19's weights were not completed daily per the physician's orders and medications were administered outside of the established parameters for Residents 2, 6, and 34. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0684		
F 0688 SS=D		F 0688		

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F 0688 SS=D	Continued from page 16 483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 0688	Unable to correct past events Current residents on RNP were reviewed for appropriate documentation to support the offering of RNP as ordered. Current nursing staff re-educated on RNP policy and procedure. Random audits to be completed by DON/ Designee to ensure offering of RNP with appropriate Documentation x4 weekly x2 monthly and report results to QAPI committee	Completion Date: **09/23/2025** Status: **APPROVED** Date: **08/26/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395627	A. BLDG: 00 B. WING:	08/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
FAIRLANE GARDENS NURSING AND REHAB AT READING STATE LICENSE NUMBER: **026202**	**21 FAIRLANE RD READING, PA 19606**

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F 0688 SS=D	Continued from page 17 Based on clinical record review and interview, it was determined that the facility failed to provide treatment and services to prevent a reduction in range of motion and/or to improve or maintain mobility on a consistent basis for two of 24 sampled residents. (Residents 27, 78) Findings include: Clinical record review revealed that Resident 27 had diagnoses that included muscle weakness and difficulty in walking. The Minimum Data Set (MDS) assessment dated June 18, 2025, indicated that the resident was cognitively impaired and required limited assistance from staff for activities of daily living. On April 17, 2025, the physical therapist had recommended a Restorative Nursing Program (RNP) for ambulation. A physicians order dated April 17, 2025, directed staff to provide the RNP for 15 minutes twice a day, seven days a week. There was a lack of documentation to support that between July 16, 2025, through August 13, 2025, the resident was offered restorative ambulation	F 0688		

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F 0688 SS=D	Continued from page 18 twice a day, as ordered, on 30 of 30 days. Clinical record review revealed that Resident 78 had diagnoses that included anoxic brain damage (lack of oxygen to the brain), persistent vegetative state, and right and left-hand contractures. The MDS assessment dated July 15, 2025, indicated that the resident was cognitively impaired and dependent on staff for all activities of daily living. A physicians order dated June 7, 2024, directed staff to provide a RNP for passive range of motion to the upper extremities, fingers and shoulders,15 minutes twice a day, seven days a week. On May 7, 2025, the occupation therapist recommended a range of motion program be continued for the bilateral should and fingers. There was a lack of documentation to support that between July 15, 2025, and August 12, 2025, the resident was offered the RNP twice a day, as ordered, on 18 of 30 days. In an interview on August 14, 2025, at 10:05 a.m. the Director of Nursing confirmed that there was no documented evidence that the RNPs were offered	F 0688		

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F 0688 SS=D	Continued from page 19 on the previously mentioned dates, twice a day, as ordered, to Residents 27 and 78 consistently. In an interview on August 14, 2025, at 11:15 a.m., the Director of Rehabilitation stated Resident 27 needed the RNP for mobility and Resident 78 needed the RNP for hand contractures. CFR 483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility Previously cited 7/12/24 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0688		

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P 5520	Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	This is unable to be corrected as it is a past event The use of an outside Recruiting Group has assisted with filling vacancies and qualified ancillary staff assist with NA coverage. Daily staffing huddles occur in which census, open holes, call offs etc.. is addressed Education to be completed with Nsg Administration, Scheduling and HR on importance of maintaining DOH guidelines as it pertains to NA ratio Audits to be completed daily by NHA/designee x4 weeks, then bi-weekly x2 weeks, then monthly x2 with. results to QAPI meeting	Completion Date: **09/23/2025** Status: **APPROVED** Date: **08/26/2025**

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

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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P 5520	Continued from page 1 Based on a review of nursing time schedules, it was determined that the facility failed to meet the minimum nurse aide (NA) to resident ratios for 21 of 21 days reviewed. Findings include: Review of nursing schedules for 21 days from July 24, 2025, to August 13, 2025, revealed the following: The facility failed to meet the minimum NA to resident ratio of one NA for ten residents on day shift (7:00 a.m. to 3:00 p.m.) on July 24, 25, 26, 27, 28, 30, 31, and August 1, 2, 3, 4, 6, 9, 10, 11, 2025. The facility failed to meet the minimum NA to resident ratio of one NA for 11 residents on evening shift (3:00 p.m. to 11:00 p.m.) on July 24, 2025 through August 7, 2025, and August 9 through 13, 2025.	P 5520		

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P 5520	Continued from page 2	P 5520		
P 5530	Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	Unable to correct past event The use of an outside Recruiting Group has assisted with filling vacancies and qualified ancillary staff assist with LPN coverage. An internal agency has been developed that does assist with providing less desirable shift (2nd and 3rd) coverage; Daily staffing huddles occur in which census, open holes, call offs etc. is addressed Education to be completed with Nsg Administration, Scheduling and HR on importance of maintaining DOH guidelines as it pertains to LPN ratio Audits to be completed daily by NHA/designee x4 weeks, then bi-weekly x2 weeks, then monthly x2. with results to QAPI meeting	Completion Date: **09/23/2025** Status: **APPROVED** Date: **08/26/2025**

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P 5530	Continued from page 3 Based on a review of nursing time schedules, it was determined that the facility failed to meet the minimum licensed practical nurse (LPN) to resident ratios for 14 of 21 days reviewed. Findings include: Review of nursing schedules for 21 days from July 24, 2025, to August 13,2025, revealed the following: The facility failed to meet the minimum LPN to resident ratio of one LPN for 25 residents on day shift (7:00 a.m. to 3:00 p.m.) on July 24, 26, 27, and 29, 2025, and August 2, 3, 6, 7, and 10, 2025. The facility failed to meet the minimum LPN to resident ratio of one LPN for 40 residents on night shift (11:00 p.m. to 7:00 a.m.) on July 25 and 27, 2025, and August 1, 8, 12, 13, 2025.	P 5530		

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P 5640	Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	Unable to correct past events The use of an outside Recruiting Group has assisted with filling vacancies and qualified ancillary staff assist with maintaining PPD. An internal agency has been developed that does assist with providing less desirable shift (2nd and 3rd) coverage Daily staffing huddles occur in which census, open holes, call offs etc. is addressed Education to be completed with Nsg Administration, Scheduling and HR on importance of maintaining DOH guidelines as it pertains to PPD Audits to be completed daily by NHA/designee x4 weeks, then bi-weekly x2 weeks, then monthly x2. With results to QAPI meeting	Completion Date: **09/23/2025** Status: **APPROVED** Date: **08/26/2025**

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P 5640	Continued from page 5 Based on a review of nursing time schedules, it was determined that the facility failed to provide a minimum of 3.2 hours of direct care for each resident for 20 of 21 days reviewed. Findings include: Review of nursing schedules for 21 days from July 24, 2025, to August 13,2025, revealed the following: Thursday, July 24, 2025: 2.96 care hours per resident. Friday, July 25, 2025: 2.77 care hours per resident. Saturday, July 26, 2025: 2.47 care hours per resident. Sunday, July 27, 2025: 2.55 care hours per resident. Monday, July 28, 2025: 2.94 care hours per resident. Tuesday, July 29, 2025: 2.95 care hours per resident. Wednesday, July 30, 2025: 2.89 care hours per	P 5640		

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P 5640	Continued from page 6 resident. Thursday, July 31, 2025: 2.80 care hours per resident. Friday, August 1, 2025: 2.54 care hours per resident. Saturday, August 2, 2025: 2.57 care hours per resident. Sunday, August 3, 2025: 2.83 care hours per resident. Monday, August 4, 2025: 2.63 care hours per resident. Tuesday, August 5, 2025: 3.03 care hours per resident. Wednesday, August 6, 2025: 3.01 care hours per resident. Thursday, August 7, 2025: 2.98 care hours per resident. Saturday, August 9, 2025: 2.81 care hours per resident. Sunday, August 10, 2025: 2.79 care hours per resident. Monday, August 11, 2025: 2.92 care hours per resident.	P 5640		

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P 5640	Continued from page 7 Tuesday, August 12, 2025: 3.02 care hours per resident. Wednesday, August 13, 2025: 3.03 care hours per resident.	P 5640		

Certified End Page

FAIRLANE GARDENS NURSING AND REHAB AT READING

STATE LICENSE NUMBER: 026202

SURVEY EXIT DATE: 08/14/2025

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