STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395380	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saunders Nursing and Rehabilitation Center	100 Lancaster Avenue Wynnewood, PA 19096

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of facility documentation, and staff and resident interviews, it was determined that the facility failed to ensure residents were kept free from abuse and neglect for two of three residents reviewed (Resident R1 and R3). Findings Include: Review of facility policy Abuse Policy - Prevention and Management reviewed August 2024, revealed the facility prohibits the mistreatment, neglect, and abuse of residents. The facility must provide a safe resident environment and protect residents from abuse. Review of Resident R1's clinical record revealed a quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated May 3, 2025, which indicated the resident was cognitively intact, determined by a Brief Interview for Mental Status (BIMS) score of 15. Continued review of Resident R1's quarterly MDS dated [DATE], revealed the resident had diagnoses of anxiety (feeling of worry, fear, nervousness) and depression (persistent feeling of sadness and loss of interest). Review of facility documentation originally submitted to the State Survey Agency on May 25, 2025, revealed Resident R1 alleged on May 24, 2025, the nurse aide, Employee E3, hit Resident R1's foot with a linen cart and was verbally abusive toward the resident. Review of statement by Registered Nurse (RN), Employee E4, dated May 24, 2025, revealed on 5/24/2025 at approximately 5:15 p.m. Resident R1 called for the nurse and subsequently reported to the RN, Employee E4, that nurse aide, Employee E3, purposely hit the resident's foot with a cart. Nurse aide, Employee E3, overheard Resident R1 speaking with Registered Nurse, Employee E4, and came out of a room and began yelling at the resident. Further review of the statement by Registered Nurse, Employee E4, revealed the nurse aide, Employee E3, began verbally attacking the resident saying, I should throw you out of that chair, then you'll see . if my people were up here then you would find out!. As the Registered Nurse, Employee E4, was escorting nurse aide, Employee E3, off the nursing unit they passed Resident R1's room and the nurse aide, Employee E3, stopped at the resident's room yelling You are a lucky b*!~ because my family isn't here. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of the statement by Registered Nurse, Employee E4, revealed 911 (Emergency Medical Services) was promptly called and when police arrived the nurse aide, Employee E3, was escorted out of the building and trespassed from the property. Interview with the Nursing Home Administrator on 6/17/2025 at 10:00 a.m. revealed that nurse aide, Employee E3, was an agency employee and the staffing agency was notified that the employee was no longer allowed to return to the building to work. Based on staff witness statements and staff interview, it was confirmed that nurse aide, Employee E3, was verbally abusive, loud, and threatening toward Resident R1. Review of Resident R3's clinical record revealed a quarterly MDS dated [DATE], which indicated that the resident was cognitively intact, determined by a BIMS score of 15. Continued review of Resident R3's clinical record revealed the resident had diagnoses of depression, muscle weakness, and need for assistance with personal care. Review of facility documentation submitted to the State Survey Agency revealed on May 14, 2025, on the 7:00 a.m. to 3:00 p.m. shift, Resident R3 reported to nurse aide, Employee E7, that on the previous shift (May 13, 2025, 11:00 p.m. to 7:00 a.m.) the resident needed to be changed but was afraid to put the call bell on to ask for assistance. Resident R3 reportedly overheard his/her assigned nurse aide, Employee E8, in the hallway saying, why does [he/she] keep putting the call light on I already went in there twice and gave water. Resident R3 reported feeling intimated and did not want to report in fear of retaliation. Review of statement by nurse aide, Employee E8, dated May 15, 2025, revealed the employee indicated that on May 13, 2025, during the 11:00 p.m. to 7:00 a.m. shift Resident R3 was dry during rounds at 12:00 a.m., was given water but not changed at 4:00 a.m., and subsequently Resident R3 was given care and changed at 6:00 a.m. with the assistance of the charge nurse, Employee E9. Review of facility documentation dated May 19, 2025, revealed licensed nurse, Employee E9, was interviewed and was unable to support the claims that he/she was present for care at 6:00 a.m. per nurse aide, Employee E8's statement. Review of statement dated May 19, 2025, by Nurse aide, Employee E7, revealed on May 14, 2025, around 7:45 a.m. [Resident R3] stated to me that [he/she] had on the same brief from yesterday [May 13, 2025] that I put on at 10:00 p.m. Resident R3 reported to nurse aide, Employee E7, that he/she did not get changed at all by assigned nurse aide, Employee E8, through the May 13, 2025, 11:00 p.m. to 7:00 a.m. shift. Further review of statement by nurse aide, Employee E7, revealed Resident R3's bed was soaked, and the whole bed had to be changed. Nurse aide, Employee E7, indicated that the bed needed to be cleaned with bleach due to the strong urine odor. Continued review of facility documentation revealed the facility expanded the investigation and interviewed similar residents who were under the care of nurse aide, Employee E8, during May 13, 2025, 11:00 p.m. to 7:00 a.m. shift. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility documentation revealed Resident R4 was interviewed who reported nurse aide, Employee E8, makes the resident feel uncomfortable by saying mean things such as you have to wait, with a nasty disposition. Resident R4 reported that nurse aide, Employee E8, started the shift with an attitude and is very inpatient. Based on staff statements and interviews the facility subsequently substantiated allegation of mental abuse and neglect. Nurse aide, Employee E8, was terminated as an employee of the facility as of May 20, 2025. 28 Pa. Code 201.29 (c) Resident rights.