

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395380	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Saunders Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on review of facility policy, review of clinical records, and staff interviews it was determined the facility failed to ensure that residents were free from neglect for one of five residents reviewed. (Resident R1) Findings include: Review of policy titled Abuse Policy -Prevention and Management, last revised August 2025, revealed The Facility prohibits the mistreatment, neglect, and abuse of residents/patients and misappropriation/exploitation of resident/patient property by anyone including staff, family, friends, visitors, etc. The Facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation/exploitation of property. The facility must provide a safe resident environment and protect residents from abuse. This includes but is not limited to freedom from corporal punishment and involuntary seclusion. A review of Resident R1's clinical record revealed an admission date of March 11, 2020, with diagnosis of muscle weakness, contracture of multiple sites, chronic fatigue, and multiple sclerosis (autoimmune disorder that affect the central nervous system). Review of Resident R1's annual Minimum Data Set (MDS- assessment of resident care needs) dated September 25, 2025, revealed Resident R1 had a BIMS (Brief interview of Mental Status) of 15 which indicated the resident's cognitive intact. Continued review of the MDS assessment revealed the resident was dependent for bed mobility and was dependent on staff for transfers to and from bed to chair. MDS assessment also revealed, dependent status coding indicates Helper does all of the effort. Residents do none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. Review of Resident R1's care plan dated October 6, 2025, revealed Resident R1 required functional level of assist is max assist for bed mobility and use of Hoyer lift for transfers in/out of bed to power wheelchair . resident is to have 2 people with care/bed mobility and transfers. Review of documentation submitted to the State Survey Agency on December 10, 2025, revealing On 12/18/2025, during the evening shift, Resident R1 fell from bed while receiving care. Resident R1 was turning to her side with the assistance of the certified nurse, [Employee E10]. As she turned on her side she slid from the side of the bed onto her knees and onto the floor. Upon immediate assessment, [Resident R1] sustained no obvious injuries, bruises or swellings, however she did complain of bilateral knee pain. Physician was notified and new order noted for x-ray of bilateral knees to rule out fractures. An investigation was started to rule out abuse and neglect, which revealed that agency staff, [Employee E10], failed to follow the plan of care for [Resident R1] by performing bed mobility without a 2-person present and was using her personal cellphone and wearing ear buds in the resident care area at the time of the incident. [Resident R1] is AAOx3 (person, time and place) with BIMS 15, is bed bound, she requires a total lift for transfers and 2 people for care/bed mobility. Resident R1 was interviewed and stated that while she was receiving care, the aid was alone, on her phone and wearing ear buds. The facility made [Employee E10] a do not return to the facility and reported her to her agency. The facility immediately began to re-educate all license and certified nursing staff on following the plan of care with regards to bed mobility and performing care and on the facility's no tolerance policy for cell phone use/earbuds in the resident care areas. Facility has substantiated the allegation of neglect regarding [Employee E10]. On December 18, 2025, at 10:39 a.m., an interview was conducted with Resident R1, who reported that she experienced a fall on December 8, 2025, during the evening shift and received care from only one nursing aide, Employee E10, who was on her cell phone and wearing earbuds. Resident R1 reported that she did not sustain any injuries and experienced only minor pain after the fall. She also stated that nursing staff did not come to assess her on the night of the fall. A review of the facility's internal investigation revealed statement from the nurse aide, Employee E10 which revealed the following I was changing [Resident R1] and as I went to turn her she wasn't holding on to the rail and her feet was hanging off the bed a little so I went over to try and put back up but couldn't so I just slid her down to the floor and went and got help to put her back on the bed I got done changing her asked if she was okay and she said yes I asked her if anything hurt she said her knee was hurting a little I don't think it was from that because she didn't hit the floor. Review of nursing note dated December 9, 2025, written by licensed nurse Employee E9, revealed: The resident mentioned to the aide that during PM care the previous night, she bumped her knees during a transfer. Neurological checks were initiated, and vital signs were obtained; all were within normal limits. The resident was offered Tylenol but denied any pain or discomfort. No signs of distress were noted. An X-ray was ordered. The physician and POA were notified. On December 18, 2025 at 2:05 an interview with the Director of Nursing Employee E2</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical record reviews and interviews with staff, it was determined that the facility did not ensure that all allegations of neglect were reported immediately to the Pennsylvania Department of Health for one of 5 residents reviewed. (Resident R1). Findings Include: A review of the facility policy titled Incident Reporting and investigation of accident hazards, supervision, assistive device, last updated October 2025, revealed It is the policy of the Facility to monitor and evaluate any adverse occurrence which is not consistent with the routine operation of the Facility or care of a resident(s). All accidents/incidents where there is mistreatment, neglect, abuse or injuries of unknown origin will be reported to the Director of Nursing (DON) and Administrator (NHA) immediately for further review and reporting based on State and Federal regulations. A review of Resident R1's nursing notes revealed admission date of March 11, 2020, with diagnosis of muscle weakness, contracture of multiple sites, chronic fatigue, and multiple sclerosis. Review of Resident R1's annual Minimum Data Set (MDS- assessment of resident care needs) dated September 25, 2025, revealed Resident R1 had a BIMS (Brief interview of Mental Status) of 15 which indicated the resident's cognitive intact. Continued review of the MDS assessment revealed the resident was dependent for bed mobility and was dependent on staff for transfers to and from bed to chair. MDS assessment also revealed, dependent status coding indicates Helper does all of the effort. Residents do none of the effort to complete the activity. 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An investigation was started to rule out abuse and neglect, which revealed that agency staff, [Employee E10], failed to follow the plan of care for [Resident R1] by performing bed mobility without a 2-person present and was using her personal cellphone and wearing ear buds in the resident care area at the time of the incident. [Resident R1] is AAOx3 (alert and oriented to people, places and time) with BIMS 15, is bed bound, she requires a total lift for transfers and 2 people for care/bed mobility. Resident R1 was interviewed and stated that while she was receiving care, the aid was alone, on her phone and wearing ear buds. The facility made Employee E10 a do not return to the facility and reported her to her agency. The facility immediately began to re-educate all license and certified nursing staff on following the plan of care with regards to bed mobility and performing care and on the facility's no tolerance policy for cell phone use/earbuds in the resident care areas. 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A review of the facility's internal investigation revealed statement from the nurse aide, Employee E10 which revealed the following I was changing [Resident R1] and as I went to turn her she wasn't holding on to the rail and her feet was handing off the bed a little so I went over to try and put back up but couldn't so I just slid her down to the floor and went and got help to put her back on the bed I got done changing her asked if she was okay and she said yes I asked her if anything hurt she said her knee was hurting a little I don't think it was from that because she didn't hit the floor. Review of nursing notes dated December 9, 2025, written by licensed nurse Employee E9 revealed: The resident mentioned to the aide that during PM care the previous night she</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on review of facility documentation, observations, and resident and staff interviews, it was determined that the facility failed to serve food at the proper temperature. Findings Include: A review of the facility's policy titled Food Temperatures Policy, revised February 2025, revealed that all hot food items must be cooked to appropriate internal temperatures and held and served at a temperature of at least 135 F. Temperatures must be taken frequently to monitor safe food-holding ranges of at or below 41 F for cold foods and at or above 135 F for hot foods. On December 18, 2025, at 10:39 a.m., an interview was conducted with Resident R1, who reported that the breakfast received that morning included sausages and pancakes that were served cold. On December 18, 2025, at 12:37 p.m., an interview was conducted with alert and oriented Resident R3, who reported a grievance regarding her dinner being served cold on December 13 and December 16, 2025. On December 18, 2025, at 12:27 p.m., a test tray was conducted with the Dietary Director, Employee E4. The following food temperatures were recorded: steamed broccoli at 121.8 F, sweet potatoes at 126 F, honey garlic chicken at 121.3 F, and juice at 46.3 F. Temperatures were taken by the Food Service Director (FSD), Employee E4, who confirmed that these foods were outside the acceptable temperature range for palatability. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management</p>		