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	02/04/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of resident records, facility policy, and staff interviews, it was determined that the facility failed to provide discharge instructions and prescription medication upon discharge (Resident R1). Findings:Review of the Facility's Policy titled Discharge Transition Packet Instruction, last revised 6/2025 revealed, The facility will complete discharge transition instruction when the resident/patient is anticipating discharge to a private residence, or personal care/assisted living. The instruction will assist the resident/patient to adjust to returning to his/her previous living environment safely or to a new living environment in a safe manner.A review of the clinical record for Resident R1 revealed a admission date October 14, 2025, with diagnosis of cervical disc degeneration, radiculopathy lumbar, hemiplegia, end stage renal disease, muscle wasting atrophy, difficulty in walking, need for assistance with personal care, chronic diastolic, thrombocytopenia, A review of Resident R1's admission Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 15, reflecting cognitive intact. A clinical progress note dated January 29, 2026, stated that on January 27, 2026, and January 29, 2026, the social worker contacted the resident's family members via email to clarify prior communication and provide follow-up regarding referrals initiated by social services for potential facility-to-facility transfers to other rehabilitation facilities. At that time, Resident R1 had not been accepted for transfer to another facility. Due to the exhaustion of Resident R1's Medicare benefits as of January 29, 2026, and because provisions for an extended stay had not been secured, the facility planned to proceed with discharge on [DATE]. Referrals were initiated for skilled home care services, including physical therapy, occupational therapy, and nursing services. Referrals for custodial home care services could also be made upon request. A post-discharge appointment with Resident R1's primary care provider was to be scheduled. Transportation was arranged for 10:00 a.m. on January 30, 2026.A separate clinical progress note dated January 29, 2026, at 1:42 p.m. revealed that a resident's family member responded that the family had already submitted medical necessity forms on behalf of the resident and that a durable medical equipment (DME) referral from [NAME] was not needed at that time.Another clinical progress note dated January 30, 2026, was written by Licensed Nurse Employee E6, stating that the resident was discharged to home at 9:35 a.m., first going to dialysis and then transferring home. All personal belongings remained at the facility, awaiting family pickup and receipt of discharge instructions and prescriptions.Further review of the clinical file revealed a copy of the discharge summary signed by Registered Nurse Employee E4 on January 30, 2026. The medication section of the discharge summary indicated the following:Glucosamine-Chondroitin oral tablet: 1 tablet by mouth every 8 hours. The last dose was administered on January 30, 2026, at 6:00 a.m., with the next dose due at 2:00 p.m.Auryxia oral tablet 1 g/210 mg (Fe): 1 tablet by mouth three times daily. The last dose was administered on January 30, 2026, at 9:00 a.m., with the next dose due at 2:00 p.m.Gabapentin oral tablet 100 mg: (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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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1 tablet by mouth twice daily. The last dose was administered on January 30, 2026, at 9:00 a.m., with the next dose due at 5:00 p.m.Dorzolamide HCl-Timolol Maleate 2%-0.5% ophthalmic solution: 1 drop in the right eye twice daily. The last dose was administered on January 30, 2026, at 9:00 a.m., with the next dose due at 5:00 p.m.Prednisolone acetate ophthalmic suspension 1%: 1 drop in the right eye every 8 hours. The last dose was administered on January 30, 2026, at 6:00 a.m., with the next dose due at 2:00 p.m.On February 4, 2026, at 12:52 p.m., Registered Nurse Employee E4 was interviewed and confirmed that the resident was discharged on January 30, 2026, at 9:35 a.m., but she did not sign the discharge packet until approximately 9:00 p.m. during her night shift, which was after the resident had already left the facility. Employee E4 stated that she was unable to provide the discharge packet to the resident because the resident was no longer at the facility.Employee E4 explained that the facility typically discharges residents even when they have scheduled appointments prior to going home. She stated that when a resident has an appointment, as Resident R1 did with a scheduled dialysis appointment, the discharge should normally be completed before the appointment, and the resident's discharge instructions, prescriptions, and belongings should be made available for the resident to take with him before leaving the facility. In this case, however, Resident R1 left the facility without receiving discharge instructions, prescriptions, or personal belongings.There was no documentation indicating that the resident refused to sign or receive the discharge instructions or prescriptions. Additionally, it was determined that the nurse responsible for the discharge is expected to review discharge instructions with the resident to ensure understanding and to provide prescriptions. Employee E4 confirmed that she was not the nurse who discharged the resident, and that the discharge instructions were not provided to Resident R1 at the time of discharge.As a result, Resident R1 was discharged without receiving required discharge instructions, medications, or personal belongings, indicating a breakdown in the facility's discharge process and a failure to ensure a safe and complete transition from the facility to home.On February 4, 2026, at 2:06 p.m., an interview was conducted with the Administrator, who confirmed that the resident was alert and oriented and should have received discharge instructions and prescription medication upon discharge on [DATE], at 9:35 a.m. There was no documentation in the clinical file indicating that the facility offered the discharge summary with prescription medication instructions. The clinical file also lacked documentation showing that the resident was offered the information and refused to sign or receive a copy of the discharge summary.The resident's representative arrived to pick up the resident's discharge instructions and prescription documentation on January 30, 2026, at approximately 9:00 p.m., which indicates that the resident was inappropriately discharged without discharge instructions, prescription medication.28 PA. Code 201.14(a)(b) Responsibility of licensee28 PA. Code 201.29(c.3) Resident rights28 PA. Code 211.12(d)(1) Nursing services

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to ensure that all residents had access to a call bell for assistance from staff for 6 of 10 residents observed. (Resident R3, R4, R5, R6, R8, R10).Findings Include:On February 4, 2026, at 10:39 a.m., an observation was conducted with the Director of Nursing, Employee E2, regarding the following residents:Resident R8's call bell was located behind her nightstand dresser, covered with a pillow, and was not accessible to resident.Resident R3's call bell was observed on the dresser and was not within reach.Resident R7's call bell was behind the bed and not accessible to the resident.Residents R5 and R6's call bells were hanging down and out of reach. A family member sitting next to Resident R6 reported that her call bell is often found on the floor and not accessible.Resident R10's call bell was wrapped behind her bed and not accessible to resident. These observations indicate that multiple residents did not have call bell that was accessible to them to request assistance.28 Pa. Code 201.14 (a) Responsibility of licensee28 Pa. Code 201.18 (b)(1) Management