

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 04/24/2026
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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, review of clinical records, and facility documentation, it was determined the facility failed to ensure the safe handling of meal carts for one of one resident reviewed (Resident R1). This failure resulted in actual harm to Resident R1 when the meal cart rolled over resident's foot resulting in a fracture of the right distal 3rd metatarsal. This deficiency was identified as past non compliance. Findings include: Review of Resident R1's April 2026 physician orders revealed the diagnoses of Hypertension (high blood pressure); Peripheral Vascular Disease (poor circulation of the extremities); Congestive Heart Failure (excessive body/lung fluid caused by a weakened heart muscle), and Alzheimer's disease (progressive degenerative disease of the brain). Review of documentation submitted to the State Survey Agency on March 26, 2026, revealed a dietary staff member (Employee E3) ran over a resident's foot (Resident R1) during meal service. Further review of the description of the event revealed, Per the aide, as he passed room [ROOM NUMBER], he heard the resident state ouch, you ran over my foot. Per the aide, (resident) was not visible in the hallway. She was sitting in her wheelchair inside the doorframe of her room; however, she had her legs extended out into the hallway. The aide states he did not see (resident)'s feet as he passed. Continued review of the submitted incident details revealed the resident was assessed after the incident, complained of pain to (her/his) right foot, and that there was a laceration noted to the bottom of (her/his) right foot. An x-ray was ordered of the resident's right foot which revealed a nondisplaced fracture of the distal 3rd metatarsal (fracture of the long bone of the 3rd toe). The physician was notified and ordered for the resident to be follow with the podiatrist at the facility and to be no weight bearing on the right foot. Review of written statement dated March 26, 2026, with the dietary aide, (Employee E3) noted that the dietary aide (Employee E3) was pushing the cart down the hall to deliver the cart. Dietary aide (Employee E3) reported that prior to the incident he was walking the cart down the back hall. Dietary aide (Employee E3) reported that he did not see the resident, did not see (resident) feet, but stated the way that the resident was sitting, only the resident's feet were in the hallway and the resident's body was positioned inside the door frame. Employee E3 reported in his statement that there was nothing that obstructed his line of sight, but the hall had medication carts so that he had to maneuver, in addition to residents who were in the hall. Dietary aide (Employee E3) reported that he did not announce his presence to let anyone know that he was coming through the hallway. Dietary aide, (Employee E3) reported that when he hit the resident's foot with the cart, the resident said, ouch the cart hit me. Dietary aide, (Employee E3) reported in his statement that he notified nursing staff of what occurred. During an interview with the Dietary aide, (Employee E3) on April 24, 2026, at 10:26 a.m. he acknowledged that the incident occurred and reported that he could only see the resident's feet hanging out. Dietary aide (Employee E3) revealed he was not looking down at the floor and that when pushing a cart, he was instructed to look forward and to the side. Dietary aide revealed he could see over the cart. He was pushing the food cart but had to move around the medication carts and the hampers that were on the floor. This caused him to go to the side of where the resident was sitting in (her/his) doorway. During the interview, the Dietary aide, (Employee (continued on next page)</p>

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 0689 Level of Harm - Actual harm Residents Affected - Few	E3) reported he did not know that he went over the resident's feet. Dietary aide, Employee E3 reported that the nurses heard the resident's yell, and they came immediately. Review of written interview dated March 25, 2026, between Licensed nurse (Employee E4), and facility personnel, revealed Licensed nurse reported she heard the resident screaming as she was at the nursing station. Licensed nurse, (Employee E4) indicated she observed the resident sitting in the doorway of her room in her wheelchair with one of her feet under the food cart. During an interview with the Licensed nurse, Employee E4 on April 10, 2026 at 11:03 a.m. the licensed nurse revealed she heard the resident scream, my foot, my foot, and observed the resident sitting in the doorway of her room on the 1st floor with her foot under the food truck the dietary aide was pushing. Licensed nurse, Employee E4 revealed the resident's toe was eventually found to be fractured and reported that the dietary aide was maneuvering his dietary cart around medication carts, etc. that were in the hallway. The facility failed to ensure that a meal cart was handle in a safe manner. This failure resulted in actual harm to Resident R1 when the meal cart rolled over the resident's foot resulting in a fracture of the right distal 3rd metatarsal (bone in toe). On April 7, 20206, the Nursing Home Administrator presented documentation, indicating that the facility initiated a plan of correction on March 25, 2026, to address safe transportation of meals. Facility plan of correction included the following: The resident involved in the incident was immediately assessed by nursing staff.-Physician and responsible party were notified- 3/25/26-pain assessment and skin assessment were completed - 3/25/26-X-ray ordered and completed revealing a non-displaced fracture of the tip of the right metatarsal- 3/25/26The staff member (Employee E3), Dietary aide was:-Immediately removed from cart handling duties pending review- 3/25/26-Re-educated on safe meal cart handling and resident awareness- 3/26/26-Completed competency validation prior to returning to full duties- 3/26/26Staff Education & Competency-All dietary staff will receive mandatory in-service on safe meal cart handling and resident awareness- Completed 100% on 3/26/26The facility will implement the following monitoring plan:-5 random observations per week for 4 weeks, then monthly x 2 months to be conducted by dietary manager/designee, any observation unsafe practices will result in immediate corrective action.-Findings will be review in QAPI meetings. Trends will be analyzed and additional interventions implemented as needed. Review of facility documentation revealed that trainings and audits with the dietary staff on Safe Meal Cart Handling & Resident Safety were conducted. The training included for dietary staff to maintain clear line of sight at all times; move carts at a slow controlled speed; be aware of resident feet and mobility devices; use caution at corners and in crowded hallways; stop immediately if unsure of surrounds and report hazards or equipment issues immediately. It was determined that the plan of correction was implemented and the deficiency was identified as past non-compliance. 28 Pa. Code 201.18(b)(3)(e)(1) Management 28 Pa Code 211.10(d) Resident care policies		