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	07/19/2024

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

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609 Based on review of facility documents, review of facility policy, review of clinical records, and staff interviews, it was determined that the facility failed to conduct a thorough investigation of an allegation of abuse, neglect and injury of unknown origin for four of 35 resident records reviewed (Residents R120, Resident R51,R102, R33 and R371) Findings include: Review of the policy titiled Abuse policy-Prevention and Management dated September, 2023 indicated that the facility was responsible for prohibiting mistreatment, neglect and abuse of residents, misappropriation of residents by staff, family friends and visitors. The policy also indicated that the facility was responsible for implementation of policies and procedures to prevent abuse, neglect and injuries of unknown origin. The policy indicated that neglect was the failure of the facility to provide goods and services necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect occurs when the facility was aware of or should have been aware of goods or services that a resident requires but the facility fails to provide to each resident that may result in physical harm, pain, mental anguish or emtional distress. Neglect includes cases where the facility's disreguard for resident care, comfort or safety resulted or potentially resulted in physical harm, pain, mental anguish or emotional distress. The policy also indicated that upon identification of possible abuse or neglect, the facility was responsible for conducting a complete and thorough investigation into the root cause of the incident. The policy indicated that the administrator and director of nursing were responsible for interviewing the person reporting the incident, interview any witnesses to the incident, interview the resident and interview the resident's roommate. Review of facility policy Abuse Policy-Prevention and Management. revised in September 2023, ,,,,, The same policy states possible indicators of physical abuse would include injuries that is suspicious because the source of the injury is not observed, the extent or location of the injury is unusual. Examples of injuries that could indicate abuse include injuries that are unexplained, fractures or dislocations (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled Elopement Prevention and Management dated August, 2023 indicated that it was the facility's responsibility to prevent resident elopements by identifying residents at risk for unsafe exit seeking behavior. The policy indicated that the facility was responsible for developing and implementing a care plan to prevent elopement. Elopement was a risk to the resident's health and safety that places a resident at risk for heat and cold exposure, dehydration, medical complications or being struck by a motor vehicle. Review of Resident R120 quarterly MDS dated [DATE], assessed the resident with severe cognitive impairment, no upper or lower extremity limitations, dependent (required staff to do all the effort and the resident none) for toilet hygiene showers and baths, was incontinent of bowel and bladder, diagnosed with Dementia, anxiety, depression, and psychotic disorder. Review of Resident R120's progress note revealed on December 1, 2023, the resident was found with facial grimacing, holding onto right shoulder, yelling out in pain, even if the arm was lifted very little. The note indicated the resident was alert to self with confusion and able to state the arm burned when she lifted it. An order for an x-ray was obtained dated December 3, 2023, indicating the findings revealed a moderately deformed fracture of undetermined age neck of right humerus. Recommend clinical correlation Resident R120 was sent to a orthopedic specialist on December 13, 2023 that further diagnosed Resident R120 with proximal humerus fractures (can occur in the elderly, fragility fracture). Further review of Resident R120 clinical records revealed in the past three months, prior to the onset of shoulder pain on December 1, 2023, noted no indication the resident experienced pain nor pain in her right shoulder, indicating this was a new experienced pain. Further review of the resident's record revealed no documented evidence this new onset of shoulder pain was investigated to rule out potential abuse. Interview with the DON on July 16, 2024, at 11:30 a.m. confirmed the facility did not further investigate Resident R120's shoulder pain to rule out abuse and stated, It was an old fracture. Clinical record review revealed an annual comprehensive assessment MDS (an assessment of care needs) dated April 18, 2024 for Resident R51. The assessment indicated that this resident had modified independence with cognition. The assessment indicated that Resident R51 was usually understood and usually understand, having difficulty with some words to express his needs. This assessment also indicated that Resident R51 was independent with ambulation walking ten feet. Clinical record review revealed that Resident R55 had a quarterly comprehensive assessment MDS (an assessment of care needs) dated June 13, 2024 that indicated this resident was cognitively intact. Clinical record review for Resident R51 indicated that this resident had eloped from the facility on March 8, 2024. The facility incident report indicated that Resident R51 was found in the rear of the facility in the parking lot of the facility by an employee of the facility. The facility documented in a report submitted to the Department that Resident R51 removed an alarm bracelet before exiting the building on March 8, 2024. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of the policy revealed that Failure of the Facility, its employees, or service providers to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of Resident R102's Quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated October 10, 2023, revealed that the resident entered the facility on January 11, 2023 with diagnosis' including diabetes, and Hyponatremia. Resident R 102 had a BIMs (brief interview for mental status) score of 3, indicating that resident R102 had severe impaired cognition. Continued review of resident R 102's MDS revealed that this resident's functional abilities such as being able to sit to stand, the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed required substantial maximal assistance, meaning the helper does more than half the effort. Resident R 102's ability to transfer from chair to bed was also noted as requiring substantial maximal assistance. Review of resident R102's care plan indicated that this resident requires increased assistance with functional mobility and ADLs created on January12, 2023, and requires extensive assistance with bed mobility and transfers dated January 13, 2023. Resident R102 is a total mechanical lift required with two staff members for transfer which was created on September 3, 2023. Review of facility reported document on December 31, 2023, resident R102 complained of right ankle pain. On the day of December 31, 2023 the nurse aid left the resident in her wheelchair in the resident's rooms while she attended to another resident. When she returned resident R102 was seated on her bed. The facility interviewed the employee and resident and completed the investigations and ruled out any abuse or neglect due to the resident having poor safety awareness and indicating that she transferred herself. Phone interview with employee E56 stated on July 18, 2023 at approximately 12:45p.m., Employee E56 stated that she was aware that resident R102 required a Hoyer lift for all transfers. Employee E56 also stated that resident was not able to stand or walk on her own, she left her in her wheelchair and when she returned resident R102 was seated on her bed. Employee believes that someone must have come in and moved her. Interview with resident R102's family member stated that she was unable to stand and or walk on her own. He determined that an employee transferred the resident without use of the required assisted Hoyer lift, resulting with an injury to resident R 102. Review of resident progress note, nursing note dated January 1, 2024, revealed that resident R102 complained of right ankle pain and reported that they bent her ankle backward while lifting her to the bed. Review of resident R 102's progress note, nursing note dated January 1, 2024, revealed that the resident complained of ankle pain, upon assessment the ankle appears swollen and painful to touch. Review of the facility documentation / investigation did not include the residents' assessments, or any other interviews and or determination of source of injury. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R371's Significant Change Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated January 18, 2024, after resident R 371 returned from hospital and was readmitted into the facility January 13, 2024, revealed the resident was cognitively impaired with a BIMS score of 4. Further review of the MDS indicated that resident R371 had impairment in range of motion to upper extremity on one side. The MDS revealed the resident had diagnoses including Parkinson's disease, Arthritis, and Malnutrition. Continued review of resident MDS evaluation revealed the MDS section G0130 A. Eating - how resident eats and drinks, regardless of skill was coded as Substantial, Maximal assistance -the resident is minimally involved in the activity, the helper does more than half the work. Review of Hot Liquid Safety Evaluation dated February 1, 2024, revealed that resident R371 was determined to be visually impaired, impaired cognition, altered level of conciseness, weakened upper extremity strength, tremors, demonstrated difficulty handling eating equipment, has contractures, and balance issues. Review of Physical Therapy Evaluation dated January 15, 2024, resident R371 was refered to PT due to exasperation of decrease in strength, decrease in functional mobility, decrease in transfers, reduced ability to ambulate, decreased judgement, increased need for assistance from other and reduced ADLs (activities of daily living). Further review of this physical therapy evaluation revealed that resident R371 was identified to. have Hypotonic(weak) muscle tone, kyphotic posture / gross motor coordination impaired. Resident is total dependence for mobility and transfers. Review of facility documentation reported to the Department of Health on February 1, 2024, revealed Resident R371was dining in the common room and dropped a cup of hot water on his right thigh. Upon further investigation, it was determined that lLicensed Nurse, employee E10 provided Resident R371with a cup of hot water from the kitchen lunch truck and prepared hot tea for the resident. It was further identified that the temperature of the beverage may not have been temped. Interview with Dietary staff, Employee E50 on July 17, 2024, at 11:35 a.m. revealed coffee maker was not working that day the heater element was broke he further stated the hot water and coffee dispensed from the machine was not hot. Employee stated the temps reported in the tempeture log were inaccurate Review of Resident R371's progress nurses note dated February1, 2024 revealed that the resident presented with a 7.9 x 7.8 x 0.1 cm area flat fluid filled blister. Review of facility documentation a written statement dated February 1, 2024, by Licensed nurse Employee E10 revealed that this nurse gave Mr. [NAME] tea with hot water at lunchtime, I was not aware the water was so hot. No, I did not heat the water up and no family was present. Interview with Licensed nurse, Employee E10 on July 17 at 12:40 p.m. revealed that she handed the cup of hot water to resident R1, she placed it on his lunch try. He picked it up and spilled it. Employee E10 immediately brought resident R 371 to his room, undressed him and applied cool compress. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The above interview was confirmed by unit manager licensed nurse Employee E7. Review of facility documentation revealed a written statement dated February 1, 2024, by nurse aide, Employee E55, stated Today at lunchtime Mr. [NAME] stopped me as I was collecting trays, He asked if I could help him. I answered yes, how can I help? Mr. [NAME] explained that he had dropped his tea and that he had spilled it on himself. I checked and then contacted the nurse on the floor to explain what Mr. [NAME] had told me and what I have seen. The nurse verified what she was told and asked me to get a cold compress and the nurse placed it on his leg and I went back on the floor and provided care and collect the remaining trays. PA Code 201.14(a) Responsibility of license PA Code 201.18(b)(1)(3)(d) Management

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 36609 Based on review of clinical records and facility policy and staff interviews, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan regarding one resident's chronic condition of constipation for one of 35 resident records reviewed (Resident R57). Findings include: Review of the facility's policy titled Care Planning Process and Care Conference revised on July 2023 stated it will develop the comprehensive resident centered plan of care for each resident. Each care plan need/problem must have a goal and interventions to address the need of the resident. Review of Resident R57's progress note, from the Certified Registered Nurse Practioner (CRNP) dated April 15, 2024, revealed the CRNP was alerted that the resident had no bowel movement (BM) in 96 hours. The resident was assessed and ordered Milk of Magnesia (MOM) given for constipation, and further instructed if MOM was not effective to offer a suppository. On May 6, 2024, CRNP seen Resident R57 for no BM for 48 hours and ordered nursing to initiate the bowel protocol and to give MOM. During that time, a new order was placed for Docusate to be given once a day for Resident R57's Chronic constipation. Further review of Resident R57's clinical record revealed the facility failed to develop a plan of care for the resident's diagnosis of constipation. An interview on with the Director of Nursing on July 19, 2024 at approximately 1:30 p.m. confirmed that the facility failed to develop a comprehensive care plan regarding Resident R57's chronic constipation. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609 Based on review of residents' records and facility policy and interviews with staff, it was determined that the facility failed to ensure residents received treatment and care in accordance with professional standards of practice when the facility failed to inform the physician of blood sugars outside the acceptable parameters and when insulin medication was not administered for three of 35 resident records reviewed (Resident R57, R135 and R149). Findings include: Review of the facility policy for Medication Management for unavailable medication dated April 2024 states, When medication are not received or are unavailable, the licensed nurse should initiate action in cooperation with the attending physician and the pharmacy provider. Review of Resident R57 order summary revealed an admitted [DATE] diagnosed with diabetes (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood). Review of Resident R57 nursing note dated, May 29, 2024, indicated the resident's blood sugars (BS) were being monitored due to the resident's insulin not arriving from the pharmacy. The note further stated the pharmacy will deliver the insulin tomorrow. Further review of Resident R57's clinical records revealed no documented evidence that the physician was informed of the missed dose of insulin. On July 19, 2024, at 10:30 a.m. the Director of nursing confirmed nursing failed to follow facility policy and failed inform the physician of the missed medication. Review of Resident R135 clinical record revealed an admitted [DATE], diagnosed with diabetes. Review of Resident R135 physician orders stated if blood sugars (BS) greater than 350 or physician ordered parameter, repeat the BS monitoring. Contact physician if greater than 350 [if not on sliding scale coverage] or physician ordered parameter and/or if signs/symptoms noted. Administer medications as ordered and monitor resident's status. Repeat BS one hour after treatment given and notify physician with update and any further guidance if needed. If resident's status is unchanged and physician orders resident to be transferred to the hospital, EMS is as needed contacted; assist with transfer. Provide a full report of the resident's condition including signs/symptoms, BS levels, most recent insulin or oral hypoglycemic agent, and time[s] administered. Review of Resident R135 clinical record revealed on the following days, the resident's blood sugars were elevated and not within the acceptable parameters: May 14, 2024, BS 360 March 26, 2024, BS 382 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	February 14, 2024, BS 354 January 10, 2024, BS 388 Further review of Resident R135's clinical record revealed no documented evidence the physician was notified as ordered. On July 19, 2024, at 12:30 p.m. the Director of Nursing confirmed that there was no evidence of nursing contacting the physician for further instructions. Resident R149 was admitted to the facility on [DATE], diagnosed with diabetes and Obstructive uropathy (a urinary tract disorder). Review of Resident R149's physician orders for hypoglycemia (low bs) instructed if blood sugar, less than 70mg or less than the physician's ordered parameter, as needed for asymptomatic, responsive resident: give 1 tube of glucose gel, 4oz of juice or 5-6oz soda, check BS in 15min, if greater than 130, give diabetic medications, if blood sugar is less than 70, repeat oral glucose and check blood sugar in 15 minutes or if no improvement, call physician. Hyperglycemia instructs if blood sugar is greater than 350 or physician ordered parameter, repeat the BS monitoring. Contact physician if greater than 350 [if not on sliding scale coverage] or physician ordered parameter and/or if signs/symptoms noted. Administer medications as ordered and monitor resident's status. Repeat BS one hour after treatment given and notify physician with update and any further guidance if needed. If resident's status is unchanged and physician orders resident to be transferred to the hospital, EMS. Review of Resident R149's electronic medication administration record (EMAR) revealed a hypoglycemic episode and the resident's blood sugar was documented at 47 on December 20, 2023. Further review of Resident R149's, clinical record revealed no documented evidence the hypoglycemic protocol was followed. Further review of Resident R149's EMAR revealed on 7/15/24 BS was 365, 7/13/24 BS was 364, 6/16/24 BS was 380, 3/30/24, BS was 369, 12/6/23, BS was 467, 11/14/23, BS was 392 and 388, and on 11/9/23, BS was 393, with no documented evidence the hyperglycemic protocol was followed. On July 19, 2024, at 1:15 p.m. the Director of Nursing confirmed no documented evidence the hyper/hypoglycemic protocol was followed for Resident R149. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. 36609 Based on staff interviews and the review of clinical records, it was determined that the facility failed to ensure that restorative nursing services was provided for one of 35 clinical records reviewed (Resident R47). Findings include: Resident R47 was admitted to the facility status post aftercare for right-sided neurosurgery for a brain tumor, diagnosed with seizures, and hemiplegia (one-sided weakness). Review of Resident R47 quarterly MDS (minimum data set, an assessment of resident's needs) dated May 29, 2024, indicated the resident was alert, oriented able to make her own personal decisions. Interview with Resident R47 on July 16, 2024, at 11:00 a.m. stated, I really want to walk again. When I went to PT (Physical Therapy), they would hold on to me and I would walk. I was doing really good but since therapy ended no one has helped me try to walk again. Review of Resident R47's plan of care indicated that the resident had an activity of daily living (ADL) performance deficit due to her one-sided weakness, having impaired balance, limited mobility, and limited range of motion. Interventions that were initiated on March 30, 2021 revised October 4, 2022, included Restorative Nursing Program (used to maintain the skills learned in physical therapy to prevent a decline) for ambulating 200 feet using a quad cane with nursing providing contact guard assistants (type of assistance where a caregiver places one or two hands on a patient's body to help with balance but does not help the patient perform the task, only steady the patient's body. Physician note dated. April 22, 2024, noted Resident R47 was seen and examined in follow-up to her physical therapy with the physician noting that Resident R47 Does bear weight when attended by someone assisting with her walking and gait Review of Resident R47's progress notes, June 5, 2024, care conference indicated rehab reported the resident was on PT maintenance program. Further review of Resident R47's clinical record revealed no documented evidence nursing was providing restorative therapy. On July 19, 2024, at 12:8 p.m. the Director of Nursing confirmed Resident R47'a should have been on the restorative program but the facility failed to coordinate such care with therapy. 28 Pa. Code 201.29(j) Resident rights 28 Pa Code 211.10(a) Resident care polices 28 Pa Code 211.12(d)(4)(5) Nursing services

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 48347 Based on observation, review of facility documentation and interviews with staff, it was determined that the Nursing Home Administrator and Director of Nursing failed to effectively manage the facility resulting in an immediate jeopardy situation regarding a resident assessment, monitoring and supervision, and inappropriately providing a hot beverage to a resident whom was determined to need assistance (Resident R371). Findings include: Review of the job description of the Nursing Home Administrator (NHA) revealed that, the primary responsibility is to establish and maintain systems that are efficient and effective to operate the nursing home in a manner to safely meet residents needs in accordance with the current federal, state, and local guidelines and regulations that govern long term care facilities. The job description of the Director of Nursing (DON) revealed that, the employee is responsible for effective overall management of the nursing department personnel, policies and procedures and coordination with other discipline to ensure the efficacy of nursing services. The DON ensures that all nursing interventions meet the personal, physical, and cognitive needs of each resident. Resident R371 who had been identified as have a diagnosis of Parkinson's disease with associated tremors was not adequately assessed and supervised. This resident was provided a hot beverage which spilled and sustained a serious burn injury. Review of MDS Review of Resident R371's Significant Change Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated January 18, 2024, after resident R371 returned from hospital and was readmitted into the facility January 13, 2024, revealed the resident was cognitively impaired with a BIMS score of 4. Further review of the MDS indicated that resident R371 had impairment in range of motion to upper extremity on one side. The MDS revealed the resident had diagnoses including Parkinson's disease, Arthritis, and Malnutrition. Continued review of resident MDS evaluation revealed the MDS section G0130 A. Eating - how resident eats and drinks, regardless of skill was coded as Substantial, Maximal assistance -the resident is minimally involved in the activity, the helper does more than half the work. Review of Hot Liquid Safety Evaluation dated February 1, 2024, revealed that resident R371 was determined to be visually impaired, impaired cognition, altered level of conciseness, weakened upper extremity strength, tremors, demonstrated difficulty handling eating equipment, has contractures, and balance issues. Review of facility documentation reported to the Department of Health on February 1, 2024, revealed Resident R 371 was dining in the common room and dropped a cup of hot water on his right thigh. Upon further investigation, it was determined that Licensed Nurse, employee E10 provided Resident R371 with a cup of hot water from the kitchen lunch truck and prepared hot tea for the resident. It was further identified that the temperature of the beverage may not have been temped. (continued on next page)

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	07/19/2024

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

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy Hot Liquid Safety last revised February 24, 2023, the intention of the policy was to minimize the risk for potential injury related to burns caused by hot liquids. Continued review of the facility policy revealed that residents will be evaluated up admission, readmission, quarterly and change on condition to ensure appropriate precautions will be implemented. If the resident triggers for any risk factors such as: weakened strength, impaired cognition, contractures of upper extremities, vision impairment, balance issues and nerve of muscular conditions (termers, cerebral Palsy, multiple sclerosis, Parkinson disease, cerebrovascular accident, Huntington's disease, and traumatic brain injury. Further eval should be completed by occupational therapy physical therapy and or speech therapy. Continued review of the facility policy of hot liquid safety revealed that it is the facility staff responsibility to implement interventions such as serving temperatures at point of service no greater than 140 degrees Fahrenheit, serving hot beverages in a cup with a lid, providing protective lap covering, staff supervision or assistance. Observation of the fourth floor (dementia unit) common area lunch revealed residents were served hot coffee and hot tea. Steam from atop of the cup was observed. The dietary director Employee E43 tested the tempeture of the cart carafe, the temp was reported as 152 degrees Fahrenheit. Based on the deficiencies identified in the report, the NHA and DON failed to fulfill essential duties and responsibilities of their position contributing to the immediate Jeopardy situation [refer to 689]. Pa Code 201.14 (a)Responsibility of Licensee Pa. Code 201.18 (a)Management