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	05/09/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview with residents and staff, review of clinical records and facility policy, it was determined that the facility failed to maintain resident dignity and respect three of 34 residents reviewed. (Resident R57, Resident 107 and Resident 114) Findings Include: Review of facility's policy Statement of Resident Rights revealed a resident has a right to be treated with respect and dignity. Review of facility policy Hearing Impaired Residents revised on September 22, 2022, revealed that staff will assist hearing impaired residents to maintain effective communication with clinicians, caregivers, other residents and visitors. When interacting with the hearing impaired or deaf resident, staff will: directly face the resident when speaking so he/she can follow facial expressions and lip read, if possible. Review of Resident R57's clinical record revealed that Resident R57 was admitted to the facility on [DATE], with diagnoses of, but not limited to, muscle weakness, type 2 diabetes (failure of the body to produce insulin), and kidney disease. Review of Resident R57 's MDS (Minimum Data Set- assessment of resident's needs) dated February 19, 2025 revealed that resident has a BIMS (Brief interview for Mental Status) of 15, indicating resident is cognitively intact. Review of Resident R57's Care Plan initiated June 23, 2023, revealed Resident R57 had a problem with communication. The resident was hard of hearing, wore bilateral hearing aids and frequently refused to wear them. Interventions include call resident by name or light touch to get his attention, when possible, face resident directly and establish eye contact. Observation on May 6, 2025 at 1:15 p.m. on 3rd floor, front hallway, revealed Resident R57 in wheelchair moving himself down the hallway. Nursing Aide, Employee E8 approached resident from behind pulling resident's shoulders backwards into chair roughly and telling resident You need to sit back, pick up your feet. in a loud tone of voice. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R107's clinical record revealed that Resident R107 was admitted to the facility on [DATE] with diagnoses of, but not limited to, Hemiplegia and Hemiparesis following Cerebral Infarction (Muscle weakness and partial paralysis following a stroke). Review of Resident R107' s MDS dated [DATE], revealed that resident has a BIMS of 15, indicating resident is cognitively intact. Interview with Resident R107 on May 6, 2025 at 12:30 p.m., resident stated that about a week ago, he was sick and going to the bathroom a lot and when staff came to help, they said What 's your problem. Resident revealed that staff makes statements such as That 's not my job when asked to change bedding. Review of Resident R114's clinical record revealed that Resident R107 was admitted to the facility on [DATE], with diagnosis of but not limited to Muscle wasting and Atrophy, Arthritis, Multiple rib fracture. Review of Resident R114 ' s MDS dated [DATE], revealed that resident has a BIMS of 15, indicating resident is cognitively intact. Interview with Resident R114 on May 6, 2025 at 11:05 a.m., resident stated that staff is rude and rough with care. Resident stated that staff are nasty and rude stating what do you want stop complaining. 28 Pa. Code 201.29(a) Resident Rights 28 Pa Code 211.12(d)(3) Nursing services

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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** Based on clinical record review, interviews with staff and residents and reviews of policies and procedures, it was determined that the facility failed to conduct complete and thorough investigations into allegations of abuse and neglect for six of 34 residents reviewed. (Residents R95, R55, R57, R104, R114 and R164) Findings include: A review of the facility policy titled abuse policy-prevention and management dated August, 2024 revealed that the facility's staff were responsible for prohibiting mistreatment, neglect, abuse, misappropriation of property and exploitation of the residents by anyone. The policy indicated that the facility was also responsible for implementing processes to ensure the prevention and reporting of suspected or alleged resident abuse. The policy indicated that the facility was responsible for providing a safe resident environment and protect residents from abuse, corporal punishment and involuntary seclusion. Continued review of the facility's policy revealed that neglect was failure of the facility staff to provide goods and services necessary to avoid harm, pain, mental anguish or emotional distress to a resident. The facility was to investigate the alleged abuse upon notification of the incident. The administrator and director of nursing were responsible for investigating and reporting possible abuse and neglect of a resident. The administrator and director of nursing were to conduct an investigation and document the investigation findings. Interview persons reporting the incident, interview witnesses to the incident, interview the resident, interview the resident's attending physician, review the medical record of the resident, interview staff members, interview the resident's roommate, family and visitors, interview other residents who the accused had taken care of. The administrator was responsible to notify the State agency within 2 hours after identification of alleged abuse, neglect or misappropriation of property by the electronic reporting system based on the Agency specifications. Review of clinical record review for Resident R95 revealed a quarterly Minimum Data Set (MDS assessment of care needs) dated February 6, 2025 that indicated that Resident R95 was cognitively intact and had a diagnosis of hemiplegia (paralysis to one side of the body) and cardiovascular disease. The assessment also indicated that this resident was functionally impaired on one side with upper and lower extremities and was frequently incontinent of urine and occasionally incontinent of bowel. The assessment indicated that Resident R95 was at risk for pressure sore development and required moderate assistance of staff for toileting hygiene, substancial assistance from staff with transfers from bed to chair/chair to bed, total assist of staff to get on and off the commode. Resident R95 was non ambulatory. On October 7, 2024 it was was documented on the grievance/concern form by the social worker, Employee E23, that the responsible party and family member for Resident R95 contacted the facility to report that the resident was neglected and not given timely incontinence care by the nursing assistant, Employee E20, that was assigned to her. The facility documentation and report submitted to the State agency confirmed that on October 7, 2024, Employee E23 neglected to provide timely incontinence care for Resident R95 because the nursing assistant wanted to finish the morning meal tray pass first. Resident R95 told the nursing staff that she had to requested another nursing assistant to provide her incontinence care since the aide assigned, Employee E23 neglected to provide incontinence care. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Nursing Home Administrator, Employee E1, at 8:30 a.m., on May 9, 2025 confirmed that the facility documentation on the report submitted to the Deparment that the allegation of neglect for Resident R95 was unsubstantiated. Further interview with the administrator verified that an accurate and complete investigation into the evidence surrounding the neglect of Resident R95 was not documented and available for review. Interview with nursing staff, Employees E12 and E14, at 9:30 a.m., on May 9, 2025 revealed that nursing staff were required to provide timely bowel and bladder incontinence care for each resident. The nursing staff, Employee E23 was required to seek the unit manager or other nursing staff member to relieve her of the morning meal tray pass; so that bowel and bladder incontinence care was provided to Resident R95 daily and as needed. The nursing staff, Employees E12 and E14 also reported that it was standard of nursing practice to provide timely bowel and bladder incontinence care; so that residents were not sitting in a brief of feces or urine. The nursing staff Employees E12 and E14 said that the practice of allowing residents to sit in their body waste products was undignified. Clinical record review for Resident R55 revealed a significant change MDS dated [DATE]. The MDS indicated that this resident was severely cognitively impaired, with a diagnosis of dementia and was receiving special treatment (hospice care). The assessment also indicated that this resident was always incontinent of bowel and bladder and the resident was at high risk for pressure ulcer development. The resident was assessed with functional impairments of the lower extremities and was totally dependent on staff for rolling left to right and transfers out of bed. The assessment indicated that Resident R55 was non ambulatory. On December 18, 2024 the social worker, Employee E23, documented on the grievance/concern form that the contracted registered hospice nurse, Employee E16 reported that Resident R55 needed more frequent bladder incontinence care. Interview with the contracted registered hospice nurse, Employee E16 at 10:30 a.m., on May 9, 2025 confirmed the report of observing and assessing Resident R55 with significant need of bladder incontinence care; as she and her staff were visiting the resident on December 18, 2024. The registered nurse explained that Resident R55 was visited several times a week to provide hospice care by the hospice organization. The registered nurse, Employee E16 reported finding Resident R55 saturated in urine; with evidence of brown stains on the incontinence brief on December 18, 2024. Interview with the Director of Nursing, Employee E2 verified the grievance/concern report documented by the social worker, Employee E23, on December 18, 2024. The Director of Nursing confirmed that a complete and thorough investigation into the possible negligence of incontinence care for Resident R55 on December 18, 2024 was not documented or available for review. Further interview revealed that the allegation of possible abuse and neglect of Resident R55 on December 18, 2024, as reported by the contracted hospice registered nurse, Employee E16 was not reported to the Department of Health as required. Review of Resident R57's clinical record revealed that Resident R57 was admitted to the facility on [DATE], with diagnoses of, but not limited to, muscle weakness, type 2 diabetes (failure of the body to produce insulin) and kidney disease. Review of Resident R57's MDS dated [DATE] revealed that resident has a BIMS of 15, indicating resident is cognitively intact. (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 R57's care plan initiated June 23, 2023, revealed Resident R57 has a problem with communication. The resident was hard of hearing, wore bilateral hearing aids and frequently refused to wear the hearing aids. Interventions include call resident by name or light touch to get his attention, when possible, face resident directly and establish eye contact. Observation on May 6, 2025 at 1:15pm on 3rd floor, front hallway, revealed Resident R57 in wheelchair moving himself down the hallway. Nurse aide, Employee E8 approached resident from behind pulling resident's shoulders backwards into chair and telling resident You need to sit back, pick up your feet. in a loud tone of voice. Observation reported, as stated above, to facility Administrator, Employee E1, and Director of Nursing Employee E2 on May 6, 2025 at 2:30pm. Review of report submitted to the State Agency on May 6, 2025 revealed On the afternoon of 5/6/2025, the facility became aware of an allegation of physical abuse involving [Resident R57] .Per the allegation, a witness alleges that the aide was rough when moving [Resident R57] while in the wheelchair, being pushed down the hall. Per the complaint, [Resident R57] was told sit back and lift your legs up. The facility failed to include the detailed information that the resident was approached from behind and nurse aide, Employee E8 pulled resident's shoulders backwards into the chair. Clinical record review for Resident R164 revealed an initial comprehensive assessment dated [DATE] that indicated this resident was cognitively intact. The assessment indicated that this resident was frequently incontinent of urine and bowel. The assessment said that Resident R164 had functional limitations of the upper and lower extremities on one side of the body; needed supervision of one staff with toileting hygiene, sit to stand, and toilet transfers (to get on and off the toilet or commode). The assessment indicated that Resident R164 required moderate assist to walk ten feet. Review of documentation on the report submitted to the Department of Health on July 26, 2024 revealed that Resident R164 reported to the occupational therapist, Employee E24, that the nursing assistant, Employee E17 was handling/holding/picking up/lifting him roughly and hit him twice on his head on July 26, 2024. The occupational therapist documented that Resident R164 demonstrated how the nursing assistant grabbed his left arm so roughly that it felt like his shoulder was being pulled out causing his spasms and pain to increase in his left shoulder and arm. Resident R164 told the occupational therapist that the nursing assistant, Employee E17 told him to get into the wheel chair. Resident R164 told the nursing assistant that he was unable to walk. Interview with Employee E17, nursing assistant and perpetrator for the alleged rough handling at 1:30 p.m. on May 9, 2025 confirmed that Resident R164 was handled roughly during care on July 26, 2024. Employee E17, nurse aide explained that she was unaware of Resident R164's care needs (severely contracted left upper extremity and left lower extremity with paralysis). The interview confirmed that the nursing assistant, Employee E17 handled Resident R164 roughly on July 26, 2024. The nurse aide, Employee E17, reported that she apologized for being rough with Resident R164 during provision of incontinence care, turning and repositioning in bed and toileting care for Resident R164 on July 26, 2024. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The documentation entered by the Nursing Home Administrator, Employee E1, on July 26, 2024 indicated that the nurse aide apologized for being too rough during care to Resident R164 on July 26, 2024. The documentation on the report submitted to the Department of Health on July 26, 2024 indicated that the allegation of possible physical abuse was not substantiated. Further review of the the documentation on the report form for investigation of alleged abuse, neglect and misappropriation of property submitted to the Department on July 26, 2024 revealed that Resident R164 provided the facility with a statement that indicated he was denied a snack when he was hungry during the eleven to seven nursing tour of duty on July 25, 2024. Resident R164 also gave a statement on July 26, 2024 that the nursing assistant was intimidating and demeaning toward him when she said that you don't know how to respect a woman. Interview with Resident R164 at 10:45 a.m., on May 8, 2025 confirmed that he was treated roughly, hit on the head and experienced increased spasms and pain by the nursing assistant Employee E17 on July 26, 2024. Resident R164 also confirmed during the interview that he was denied a snack by a nursing assistant on July 25, 2024 during the eleven to seven night tour of duty. Resident R164 explained how he was treated undignified when the nursing assistant, Employee E17 told him that he did not know how to respect a woman. Interview with the Nursing Home Administrator, Employee E1 at 8:45 a.m., on May 9, 2025 confirmed that the possible nutritonal neglect and verbal abuse as stated by Resident R164 on July 25 and 26, 2024 was not investigated by the facility. The Nursing Home Administrator confirmed that there was no complete and accurate investigation and documentation submitted to the Department of Health. related to the allegations of nutritional neglect and verbal abuse made by Resident R164 on July 25 and July 26, 2024. Review of Resident R114 ' s clinical record revealed that Resident R114 was admitted to the facility on [DATE], with diagnosis of but not limited to Muscle wasting and Atrophy, Arthritis, Multiple rib fracture. Review of Resident R114's MDS dated [DATE], revealed that resident had a BIMS of 15, indicating resident is cognitively intact. Review of Resident R114's physician order dated December 20, 2025, revealed an order for paired care at all times, every shift for accusatory behavior. Review of facility's documented investigation report dated January 7, 2025 revealed that on morning of January 7, 2025, Resident R114 asked to speak with the Nursing Home Administrator around 10:30am. Resident R114 stated that sometime last week the nurse [Employee E10] grabbed me and threw me around. Further review of facility's investigation revealed no documented evidence that interview was completed with other staff that were assigned to paired care for Resident R114. No documented evidence that interviews with other residents in the care of Employee E10 were completed. Interview with Director of Nursing, Employee E2 on May 9, 2025 at 11:00 a.m. confirmed no documented evidence that interviews had been completed for additional staff or residents in regards to event reported by Resident R114 on January 7, 2025. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on clinical record reviews, and staff interviews, it was determined that the PASRR (Pre-admission screening and resident review) was not updated for one of 34 resident reviewed. (Resident R97) Findings include: The PASRR (Pennsylvania Preadmission Screening Resident Review) was created in 1987 through language in the OMNIBUS Budget Reconciliation ACT (OBRA) and it has three goals: to identify individuals with mental illness and or intellectual disability, to ensure that they are placed appropriately, weather in the community or in a nursing facility, and to ensure they are placed they receive the services they require of their mental illness or disability. The level I must be completed on all persons who are considering admission to a Medicaid certified nursing facility. A level II PASRR evaluation must be completed if the level I PASRR determined that the person is a targeted person with mental illness of an intellectual disability. The level II PASRR would determine if placement or continued stay in the requested or current nursing facility is appropriate. Review of facility provided policy Social Service Assessment - PASRR', revised on May 7, 2025, indicates that when a new diagnosis is identified during stay at the facility, the information must be added to the level I form. Review of Resident R97's clinical record revealed that she was admitted to facility on October 15, 2021 with the diagnoses of schizoaffective disorder (mental disease characterized by loss of reality contact, delusion and feelings of persecution), and delusional disorder on August 31, 2024. Further review of Resident R97's clinical record revealed PASR level I form was completed on October 15, 2021 with a negative screen for Serious Mental Illness, Intellectual Disability/Developmental Disability, or other related condition. Interview with facility's social worker, Employee E11, on Friday, May 9, 2025, at 1:30 pm, confirmed there was no evidence that PASRR level I form was updated since August 31, 2024. 28 Pa Code 211.5(f)(iv) medical records 28 Pa Code 211.10(c) resident care policies

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F 0656 Level of Harm - 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. Based on review of clinical records, facility policy, facility investigative reports, and interview with staff, it was determined the facility failed to ensure hospice staff implemented care-planned interventions for one of 34 residents reviewed, who was identified as a fall risk. This failure resulted in actual harm to Resident R24 who sustained a fall out of bed during care, required transfer to the hospital via emergency medical services and sustained four sutures to left forehead/eyebrow and back of the head. (Resident R24) Findings include: Review of facility policy titled, Fall Prevention and Management revised January 1, 2023, revealed the interdisciplinary team identifies and implements appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence. Review of subsection titled, Procedure revealed 1. Assess and review resident risk factors for falls and injuries upon admission, re-admission, quarterly, annually a significant change and/or after a fall. Review the completed Fall Risk Assessment/ Evaluation. Review other interdisciplinary Team (IDT) assessments as they related to fall risks. 2. Implement goals and interventions with input from resident/family if able for inclusion in Interdisciplinary Plan of Care based on individual needs after attempting to determine possible causes. 3. Communicate interventions to the care giving teams and family responsible party. Review of facility policy titled, Incident Reporting and Investigation of Accident Hazards, Supervision, Assistive Devices, revised October 30, 2024, revealed assistance Devices or Assistive Device refers to any item (e.g. fixtures such as handrails, grab bars, and mechanical devices/equipment such as stand- alone or overhead transfer lifts, cane, wheelchairs, and walkers) that is used by, or in the care of a resident to promote, supplement, or enhance the resident's function or safety . Environment refers to any environment in the facility that is frequent by or accessible to resident including (but not limited to) the resident 's rooms, bathrooms, hallway, dining areas, lobby, outdoor patios, therapy areas and activity areas. Review of facility policy titled Care Planning Process and Care Conference, revised March 19, 2025, revealed the purpose of policy is to assure that all services, as outlined by the comprehensive care plan being provided, meet professional standards of quality, including activities of daily living (ADL's), falls, skin tears, risk for skin breakdown, nutritional status, behaviors . Review of Resident R24's clinical record revealed the resident's diagnoses of Dementia (progressive decline in mental ability), Parkinson's disease (disorder of central nervous system that affects movement), and Anxiety (mental health condition characterized by excessive fear or anxiety that interferes with daily activities) Review of R24's quarterly Minimum Data Set (MDS- assessment of resident's care needs) completed on August 14, 2024, revealed BIMS score of 2 which indicated the resident had severe cognitive impairment. Continued review of the MDS assessment revealed the resident was determined to require extensive assistance of one person physical assist for bed mobility. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of Resident R24's physician orders revealed an order initiated April 16, 2024, for ¼ side rail enablers to bed bilaterally to assist with bed mobility and increase functional independence. Review of Resident R24's care plan initiated November 18, 2024, revealed the care plan included the use of 1/4 siderail enablers to bed bilaterally to assist with bed mobility and increase functional dependance. Intervention listed ensure enablers are up at all times while resident is in bed. Review of information dated September 3, 2024 submitted by the facility to the Department of Health revealed, On 9/3/2024 while performing personal care, the aide from [hospice provider] turned [resident] toward her in the bed to assist (resident) with pulling up (his/her) pants. The aide was attempting to walk to the other side of the bed to finish up, and did not realize that [resident] was holding on to her (aide) pocket. [Resident R24] fell from the bed to the floor. [Resident R24] sustained a laceration to (his/her) left eyebrow and the left back side of (his/her) head. First aid was applied to the area and 911 was called. [Resident R24]'s daughter was notified regarding the fall. [Resident] was taken to [area hospital] where (he/she) received 4 sutures to (his/her) left eyebrow and 4 staples to the left back side of (his/her) head. [Resident] returned to the facility around 2028. Care plan reviewed and updated. New intervention noted for 2-person assist with bed mobility noted. Review of nursing documentation dated September 3, 2024, at 11:45 a.m. revealed the hospice nurse aide called nurse on duty for help, upon arrival resident was on the floor in supine (lying on one's back with face upward) position. Resident had two lacerations on the head, one above (his/her) left eyebrow and the left side of the head. Injury site was cleansed with normal saline, gaze applied, Bright blood noted pressure applied to the area . on O2 (oxygen) @ 2L (liters). 911 (emergency medical services) called to transfer resident to [local hospital]. Continued review of nursing notes dated September 4, 2024, revealed Resident did return with 4 sutures in left forehead/eyebrow, 4 stapes left side of head. Review of facility investigation report, completed on September 4, 2024, revealed on September 3, 2024, while receiving care from hospice nurse aide, Employee E3, at approximately 11:45 a.m., Resident R24 had a witnessed fall that resulted in a transfer to hospital where [he/she] received four sutures to [his/her] left eyebrow and four staples to the left back side of [his/her] head. Further review of same report revealed the hospice nurse aide, Employee E3 turned Resident R24 toward her in bed to assist him/her with pulling up his/her pants; the aide was attempting to walk to the other side of the bed to finish up, and did not realize Resident R24 was holding onto aide's pocket. Resident R24 fell from bed to the floor. The resident sustained two lacerations on the head. Further review of Resident R24's fall incident/accident investigation report, completed on September 3, 2024, at 11:45 a.m., revealed one of the question on the report was were proper tools/equipment being used? for which the answer was marked as no, without further description. Review of hospice nurse aide, Employee E3's statement failed to reveal evidence bilateral 1/4 side rail enablers were utilized at the time. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Interview with hospice nurse aide, Employee E3 on Friday, May 9, 2025, at 10:40 a.m., revealed Employee E3 was not aware the resident's care plan and physician's order indicated the need for bilateral ¼ side rails as mobility enablers. The facility failed to ensure hospice staff were aware of Resident R24's care plan interventions related to the use of 1/4 side rails while in bed for safety. This failure resulted in actual harm to Resident R24 who was holding onto nurse aide, Employee E3's pocket while in bed, fell out of bed when Employee E3 moved away from resident, sustaining four sutures to left forehead/eyebrow and four sutures to the back of the head. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(1)(e)(1) Management 28 Pa Code 211.12(d)(1)(3)(5) Nursing services

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	05/09/2025

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon review of clinical records, interviews with staff and residents and reviews of policies and procedures, it was determined the facility did not ensure residents receive treatment and care in accordance with professional standards of practice, by failing to follow the physician's orders for medication administration for three of 34 residents reviewed (Resident R95, R24 and R172). Findings include: Review of the facility policy titled Self- Administration of Medications dated March 2025, states medications shall be administered in a safe and timely manner and as prescribed by the physician. Medications both prescription and non-prescription shall be administered under the orders of the attending physician, or the physician's designee. Medications must be administered in accordance with the written physician orders. Residents may self-administer their own medications if the attending physician, in conjunction with the interdisciplinary Care Plan Team, has determined they have the decision-making capacity to do so safely. Review of the policy titled Medication Administration dated January, 2025, revealed that it was the responsibility of the facility staff to ensure that prescribed medications were administered to the residents in accordance with manufacturers' specifications and standards of nursing principles and practices. The policy also indicated that only licensed and authorized personnel were allowed to administer medications to the residents. Medications are to be administered at the time they are prepared by the person who prepares the dose for administration. The staff member was to explain to the resident the type of medication being administered and the procedure. The resident was to be observed by staff after the administration to ensure that the dose was completely ingested. The individual who administers the medication dose records the administration on the medication administration record immediately following the medication being given. The policy indicated that in no case should the individual who administered the medication report off-duty without first recording the administration of any medications. Review of Resident R172's clinical record revealed the resident was initially admitted to the facility on [DATE], and readmitted on [DATE], with the diagnoses of cerebral infarction, (stroke), aphasia (loss of language, unable to speak), dysphagia (unable to swallow), type two diabetes (body unable to produce insulin) and hemiplegia (one sided weakness) following the stroke that affected the resident's right dominant side. Review of Resident R172 Significant change MDS (Minimal Data Set, an assessment of residents' needs) dated April 14, 2025, indicated the resident was depended on staff for activities of daily living, that included bed mobility, toileting. bathing and feeding. Review of Resident R172's nursing notes dated April 28, 29, and April 30, 2025, revealed that the resident's grandson would visit resident and apply a hemorrhoidal cream. Review of Resident R172's April 2025 physician orders revealed that there was no physician order for hemorrhoidal cream and for the resident's grandson to apply this treatment to the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of May 2025 physician orders revealed that an order was obtained on May 2, 2025, for Preparation H External Cream 1 % (Hydrocortisone (Rectal)) was ordered for Resident R172; to apply to hemorrhoid topically every 12 hours as needed for hemorrhoid and was instructed to keep in medication drawer, not resident's room. On May 6, 2025, nursing note indicated that the staff obtained orders from the physician to allow grandson to apply the cream to Resident R172. On May 8, 2025, at 9:16 a.m. interview with the facility's Medical Director confirmed he authorized and allowed the grandson to apply the prep H medicated cream to Resident R172 but had to do so with a nurse present. Continue review of Resident R172 clinical record revealed no evidence the family member was accompanied by a nurse, nor needed to when applying the hemorrhoid cream to Resident R172. Clinical record review for Resident R95 revealed a quarterly assessment (MDS-an assessment of care needs) date February 6, 2025 that indicated this resident was cognitively intact and had functional impairments of the extremities for one side of the body. Continued review of the MDS revealed that Resident R95 required set-up assistance with eating. The assessment indicated that resident R95 had coronary artery disease, hypertension and anxiety disorder. Observations of Resident R95 at 11:15 a.m., on May 6, 2025 revealed that this resident was laying in bed with the head of the bed elevated. The resident had the over-bed table arranged in front of her as she sat up in bed. On the over bed table directly in front of and in arms reach for Resident R95 were medications. These medications were the medications to be administered at 9:00 a.m.; as ordered by the physician. The medications were as follows: Aspirin EC one tablet for cardiac disease, Centrum multivitamin one tablet for vitamin supplementation, Cholecalciferol 2000 UT one tablet for vitamin D supplementation, Clopidogrel bisulfate one tablet for antiplatelet, Diltiazem HCL one tablet for cardiac disease, Isosorbide mononitrate extended release one tablet for hypertension, Klonopin one tablet for anxiety, Pantoprazole sodium one tablet for gastric reflux disease and sertraline HCL one tablet for depression. Interview with Resident R95 at 11:10 a.m., on May 6, 2025 revealed that Resident R95 said that she could not take all of these pills at 9:00 a.m; that all at once the pills make her nauseous. Resident R95 said that she would take them. The resident was wondering if the timing and administration of her medications could be expanded throughout the day. The resident was also reporting that pudding and applesauce would help with swallowing the medications. Interview with the licensed nursing staff, Employee E14, at 11:20 a.m., on May 6, 2025 who was responsible for preparing and administering Resident R95's 9:00 a.m., confirmed that the medications were left at Resident R95's bedside. Further interview with licensed nurse, Employee E14 revealed that the nurse failed to watch the resident ingest her medications at the time the nurse gave the medications to Resident R95. (continued on next page)

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	395380	A. Building B. Wing	05/09/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy 'Oxygen Administration,' revised September 14, 2023, indicates that oxygen therapy will be administered by licensed nurses with a physician's order to provide a resident with sufficient oxygen to their blood and tissues,and the goal of oxygen therapy include, but not limited to: Reverse or prevent tissue hypoxia, treat arterial hypoxemia, decrease work of breathing, decrease myocardial work. Review of facility policy 'Physician Orders, Verbal and Telephone,' revised February 13, 2023, instructs employees to confirm accuracy of physician orders based on facility guidelines when the monthly orders/recaps are due to be reviewed. Review of Resident R24's clinical record revealed the resident had a medical history of congestive heart failure, and primary pulmonary hypertension (high blood pressure in the pulmonary arteries). Review of R24's physician orders revealed an order for oxygen 2 liters continuous via nasal cannula was discontinued on April 16, 2025. Review of R24's nursing progress notes, dated April 17, 2025, April 23, 2025, and April 25, 2025 indicated that resident continued to receive oxygen therapy. Review of R24's hospice nursing notes, dated April 17, 2025, revealed that resident was found with O2 not in place, OX 87% Interview with facility's Director of Nursing, Employee E2, on Friday, May 9, 2025 at 11:40 a.m., revealed that facility's Assistant Director of Nursing, Employee E4, discontinued the oxygen order on April 16, 2025 by accident during review of physician orders. Review of facility provided grievance report as well as follow up investigation, dated April 18, 2025, revealed that staff were educated on the process for change in condition and the safe use of supplemental oxygen and the oxygen equipment after nursing employee, E10 found R24 with disconnected nasal cannula tube from concentrator - resulting in low pulse oximeter reading. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12 (d)(1)(5) Nursing services

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	395380	A. Building B. Wing	05/09/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based up observation, interviews with staff, review of clinical records and facility policy, it was determined that the facility did not implement appropriate interventions to prevent pressure ulcers for one of 34 resident records reviewed (Resident R172). Findings include: Review of the facility's policy titles Risk Assessment and Prevention revised January 2025 states, Prevention of pressure ulcers require early identification of at-risk residents and the implementation of preventative strategies. Review of Resident R172's clinical record revealed that the resident was initially admitted to the facility on [DATE], and readmitted on [DATE], with the diagnoses of cerebral infarction due to embolism of left middle cerebral artery (stroke), hemiplegia and hemiplegia (one sided weakness) following the stroke that affected the resident's right dominant side, aphasia (loss of language, unable to speak), dysphagia (unable to swallow), and diabetes. Review of Resident R172's Significant change MDS (Minimal Data Set, an assessment of residents needs) dated April 14, 2025, indicated the resident was completely depended on staff for all activities of daily living including bed mobility, and toileting. The same MDS indicated Resident R172 was at risk for developing pressure ulcers and applications of ointments and or dressing to the feet were not used or provided. Review of the progress note from the wound consult dated February 25, 2025, stated preventative measures for Resident R172 included floating heels while in bed with the use of pillows due to the resident's increased risk of skin breakdown. Further review of Resident R172's clinical record and observation of Resident R172 during the survey process at the facility determined the resident's heels were not protected and off-loaded as recommended by the wound healing specialist. This was confirmed with the Director of Nursing on May 8, 2025 at 1:00 p.m. the facility failed to have prevented measure in place to protect Resident R172's heels. 28 Pa Code 211.10(c) Resident care policies 28 Pa. Code 211.12 (d)(1) Nursing services

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	395380	A. Building B. Wing	05/09/2025

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Saunders Nursing and Rehabilitation Center	100 Lancaster Avenue Wynnewood, PA 19096

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that weights were monitored for one of 34 residents reviewed (Resident R28). Findings include Review of facility's Statement of Resident Rights, revealed any weight change greater than or less than 5 pounds within 30 days will be retaken the next day for confirmation with licensed nurse confirming reweigh. Review of Resident R28 's clinical record revealed that Resident R28 was admitted to the facility on [DATE], with diagnoses of, but not limited to, Metabolic Encephalopathy (brain disorder that arises from disruption in body's metabolic processes), Type 2 Diabetes (failure of the body to produce insulin), and muscle wasting. Review of Resident R28 's care plan revised on May 6, 2025 revealed that resident was at risk for alteration in nutrition/ hydration related to obesity. Intervention implemented on July 15, 2025 was for weights as ordered. Review of Resident R28's physician orders revealed an order dated August 1, 2024, for monthly weight. Review of Resident 28's clinical record revealed on April 1, 2025, Resident R28 weighed 150.9 lbs. Further review of clinical record revealed on May 4, 2025, Resident R28 weighed 130.4 lbs (-20.9 lbs, -13.59%). Further review of Resident 28 's clinical record revealed no documented evidence of reweigh or nutritional assessment related to significant weight change. Interview with Registered Dietician, Employee E18 on May 9, 2025 at 10:30am confirmed no nutritional assessment completed until May 8, 2025. Interview with Director of Nursing, Employee E2 on May 9, 2025 at 10:38 a.m. confirmed no documented evidence of interventions for significant weight change and/or reweight completed until May 8, 2025. 28 Pa. Code 211.12(c) Resident care policies 28 Pa. Code: 211.12(c)(d)(1)Nursing services

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	395380	A. Building B. Wing	05/09/2025

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on review of facility policies, clinical record reviews and interviews with residents and staff, it was determined that the facility failed to ensure professional practice standards related to pain management for one of 34 residents reviewed (Resident R98). Findings include: Review of the facility's policy titled Pain Management revised March 2025 states, The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Review of Resident R98's nursing note dated April 3, 2025, indicated the resident was alert and oriented, able to make needs known. The resident admitted diagnosis was a fractured right tibia due to a fall with 14 staples to right knee, eight to shin, seven to ankle, four to front foot, and two in foot. Interview with Resident R98 on May 7, 2025, at 11:00 a.m. stated, When I first got here, they were giving me Tylenol for pain, the nurses would ask me what number my pain was, (1 out of 10, 10 being the most severe pain) but told them the Tylenol wasn't working. It took a long time for them to call the doctor to get something stronger. The doctor finally ordered Tramadol for the pain Review of Resident R98's physician orders revealed 2 tablets of 325 milligrams of acetaminophen were to be given every 6 hours as needed for Mild Pain. Review of Resident R98's April 2025 electronic Medication Administration Record (EMAR) revealed that Acetaminophen was given when the resident was experiencing moderate to severe pain; on April 3, 2025 for complaints of pain 7/10, on April 13, 2025 for complaints of pain 8/10 and on April 14, 2025 for complaints of pain 7/10. Furthermore, nursing note dated April 4, 2025, noted Resident complains of discomfort with no evidence further action was attempted to relieve the pain. It was not until April 16, 2025, 13 days since admission, an order 25 mg of Tramadol was obtained given for ':moderate to severe pain. Interview with the Director of Nursing on May 7, 2025, at 2:00 p.m. confirmed the resident's pain was not effectively being controlled and agreed the order for acetaminophen was for mild pain and 7/10 is considered moderate to severe pain. The physician should have been made aware. 28 Pa. Code 211.10(c) Resident care policies 28 Pa Code 211.12 (d)(1) Nursing services

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	395380	A. Building B. Wing	05/09/2025

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Deficiency Text Not Available

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	395380	A. Building B. Wing	05/09/2025

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, resident clinical records, and staff interviews, it was determined that the facility failed to obtain a physician order and develop a comprehensive care plan for for hospice services for one of eight residents reviewed (Resident R8). Findings include : Facility policy titled Clinical Manual/Social Services Manual last reviewed April 2025 revealed It is the policy of this facility to participate in hospice care as an approach to caring for terminally ill residents that require palliative care as opposed to providing curative care. Based on Federal guidelines, the Facility has the following options as it relates to Hospice Care: i. Arrange for the provision of hospice services through an agreement with one or more Medicare-certified. It further revealed under iii D (f). Obtaining the following information from the hospice: The most recent hospice plan of care specific to each resident (f) Hospice physician and attending physician (if any) orders specific to each patient. v. The facility must ensure that each resident's written plan of care includes both the most recent hospice. Interview conducted on June 11, 2025, at 10:43 a.m., with Licensed nurse, Employee E4, who reported that Resident R8 was a resident receiving hospice services (supportive services for end-stage terminal illness). It was further reported that hospice aide, Employee E6 had offered morning care, but Resident R8 refused. Employee E6 stated they would return in an hour to attempt to offer morning care again. Review of Resident R8's clinical record revealed that the resident was admitted to the facility on [DATE]. Review of Resident R8's physician orders did not include a physician's order for hospice care. On June 11, 2025, at 11:43 a.m., an interview was conducted with the Director of Rehabilitation, Employee E7, who confirmed that Resident R8 has half railings on her bed. According to her last physical therapy discharge evaluation, which occurred on March 23, 2025, Resident R8 could benefit from the use of the railings. Resident R8 is able to perform some movements with her upper extremities and would therefore benefit from the use of enablers during morning care. Review of Resident R8's clinical record revealed that there was no comprehensive care plan developed by the facility for hospice services and the coordination of services with the contracted hospice provider or for the use of enablers to support the resident's independence during morning care. Interview conducted on June 11, 2025, at 10:49 a.m., with licensed nurse, Employee E5, who provided a hospice communication binder. The binder reflected that Resident R8 had been on hospice since May 31, 2025, and that a hospice contractor's care plan was created on the same date. It was further revealed that the hospice care plan did not include any instructions regarding the resident's use of enablers. The last documented hospice service that was received and documented in the binder was June 9, 2025. This was confirmed by Employee E5. (continued on next page)

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	395380	A. Building B. Wing	05/09/2025

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On June 11, 2025, at 10:59 a.m., an interview was conducted with charge nurse Employee E4, who confirmed that Resident R8 had no physician order for hospice and no comprehensive care plan for hospice services or the use of enablers. Based on the clinical record and her knowledge, it was unknown how often Resident R8 received hospice services at the facility. Employee E4 further stated, 'I don't know who is responsible for entering the physician order and comprehensive care plan. On June 11, 2025, at 11:01 a.m., an email was sent to the Director of Nursing notifying them that the clinical record did not include documentation of hospice services for Resident R8. Shortly thereafter, a physician order and comprehensive care plan were entered into Resident R8's clinical file. On June 11, 2025, at 11:07 a.m., an interview was held with hospice contractor aide, Employee E6, who reported that this was her first time providing hospice services to Resident R8. Employee E6 was unsure whether Resident R8 was permitted to use enablers. When asked to describe the morning care order, she did not provide any information regarding enablers. She further reported that she follows the hospice contractor's care plan specifically designed, which she could not recall. Then access her phone to view the specific care plan for Resident R8, it was found that the care plan did not include any reference to enablers. It was also confirmed that hospice contractor aides do not have access to the facility's electronic comprehensive care plan. On June 11, 2025, at 12:33 p.m., a meeting was held with the Administrator (Employee E1), Director of Nursing (Employee E2), and Regional Nurse (Employee E10) confirmed hospice aides do not have access to residents' electronic care plans. 28 Pa. Code: 201.14 (a) Responsibilities of licensee. 28 Pa. Code: 201.18 (b)(1)(3) Management. 28 Pa. Code: 201.20(a) Staff development. 28 Pa. Code: 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.11(d) Resident care plan. 28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.

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	395380	A. Building B. Wing	05/09/2025

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and staff interview, it was determined that the facility failed to ensure that call bells were answered in a timely manner for two of 34 residents reviewed. (Resident R107 and Resident R114) Findings include: Review of Resident R107 's clinical record revealed that Resident R107 was admitted to the facility on [DATE] with diagnoses of, but not limited to, Hemiplegia and Hemiparesis following Cerebral Infarction (Muscle weakness and partial paralysis following a stroke). Review of Resident R107' s MDS (Minimum Data Set- assessment of resident's care needs) dated March 8, 2025, revealed that resident has a BIMS (Brief interview for mental status) of 15, indicating resident is cognitively intact. Interview with Resident R107 on May 6, 2025 at 12:30pm, resident stated call bell wait times can be 30 minutes sometimes. I waited an hour last week for someone to get me off the toilet. Review of Resident R114 's clinical record revealed that Resident R114 was admitted to the facility on [DATE], with diagnosis of but not limited to Muscle wasting and Atrophy, Arthritis, Multiple rib fracture. Review of Resident R114 's MDS (Minimum Data Set) dated March 20, 2025, revealed that resident has a BIMS (Brief Interview for Mental Status) of 15, indicating resident is cognitively intact. Interview with Resident R114 on May 6, 2025 at 11:30am, resident stated call bell is never answered timely. Observation on May 6, 2025 at 1:38pm revealed call bell light on for Resident R114. Further observation on May 6, 2025 at 2:01pm revealed call bell light was still on. Interview with Resident R114 on May 6, 2025 at 2:01pm revealed I am just waiting for a cup of coffee. Resident R114 stated that call bell had been on for at least 30 minutes. 28 Pa. Code 211.12(d)(1) Nursing services