

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395479	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Gwynedd Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 773 Sumneytown Pike Lansdale, PA 19446	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical records, facility documentation, and policy it was determined the facility failed to ensure Resident R109 was provided with the necessary equipment of wheelchair leg rest to ensure safety and proper positioning during transportation to an outside appointment. This failure resulted in actual harm to Resident R109 who while being wheeled out of the transportation van fell face forward from the wheelchair and sustained a right femur fracture for one of 33 residents reviewed (Resident R109). Findings included: Review of facility policy titled Wheelchair Leg Rest Usage undated, revealed The facility will ensure that residents who utilize wheelchair are transported safely. If a resident is not able to self-propel their own wheelchair or if they cannot lift their legs while being transported the staff will provide leg rests. Review of Resident R109's clinical record revealed the resident was alert and oriented, admitted to the facility on [DATE], with the diagnoses of Pulmonary Hypertension (high blood pressure that affect the arteries in the lungs), Respiratory Failure with Hypercapnia (too much carbon dioxide in the blood), Chronic Obstructive Pulmonary Disease (process that causes decreased ability of the lungs to perform), Atherosclerosis (hardening of your arteries from plaque), Heart Failure, high blood pressure, Morbidly Obese, history of multiple fractures that included, periprosthetic fracture (fracture near knee replacement), displaced fracture of greater tuberosity (shoulder), cervical spine fracture, chronic pain and depression (major loss of interest in pleasurable activities). Review of Resident R109's facility assessment titled Functional abilities and goals, three-day assessments dated January 12, 2025, and April 12, 2025, revealed the resident had no impairments of the upper and/or lower extremities, used a walker and independently used a manual wheelchair for mobility. The resident was able to wheel self, up to 50 feet with two turns and/or 150 feet. Review of Resident R109's care plan initiated in April 2021 revealed Potential for falls related to decreased mobility, poor safety awareness. Interventions included, Leg rest bag to back of w/c (wheelchair), initiated on June 26, 2023. Review of the information submitted to the State Survey Agency on February 5, 2025, Resident R109 went to an outside appointment using a transport service that was provided by the facility. The report indicated, the resident suddenly put [his/her] feet down and fell out of the wheelchair. 911(Emergency Medical Services) was called and the resident was transported to the hospital. Continue review of the facility incident report revealed the resident was admitted to the hospital with a diagnosis of right femur (thighbone) fracture. Interview with Resident R109 on December 2, 2025, at 11:00 a.m. revealed when [resident] was being wheeled by the staff member from the transport company [his/her] footrests were not on [his/her] wheelchair. Resident R109 stated (she/he) fell out of the chair, face first. I told her the footrests were between the two beds, as the resident pointed between bed and roommate's bed, but she never came back for them. Interview conducted with Nursing Home Administrator on December 2, 2025, at 1:00 p.m. revealed the facility tried to keep the resident's leg rests in a bag because so many of them were misplaced. At one point a few years back we added it to all care plans because as you can see, they are still an issue; they are here, there, and everywhere. Review of the witness statement from Resident R109's nurse aide, Employee E8 who assisted the resident to the toilet in the resident's (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
--	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395479	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Gwynedd Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 773 Sumneytown Pike Lansdale, PA 19446	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	room, prior to leaving for the doctor's appointment revealed after the resident was back in the wheelchair Nurse aide, Employee E8 left the room. When Nurse aide, Employee E8 returned to the resident's room the resident had left for the appointment and was not aware where the leg rests were. Review of facility documentation titled, Fall incident/accident investigation dated February 5, 2025, at the time of Resident R109's fall, indicated the wheelchair was used without the use of leg rest. The investigation documentation revealed, the resident Normally does not use leg rest, and the resident propels using [his/her] feet, without the use of leg rests. The investigation indicated, the cause of the fall was because the resident Put legs down while being transported. To prevent further accidents/injuries of the kind the facility concluded that Wheelchair leg rest present while being transport. Review of the witness statement by Licensed Practical Nurse (LPN), Employee E9 stated, I assisted the resident with [his/her] shawl, and [he/she] did not have leg rests on at the time of the transfer. Residents never use w/c (wheelchair) leg rest. Self propels as lib (As needed). Review of the witness statement from the transport staff member, Employee E12 who assisted the resident that day revealed she asked Resident R109 where the resident's footrest where. The transport staff said she asked the nurse, (Employee E9) that was sitting outside of the resident's room about the footrest and didn't know. Transport staff member, EmployeeE12 revealed, We still took [him/her] to the doctor appointment. When the resident was escorted off the van and Employee E12 wheeled the resident towards the doctor office, Employee E12 stated that Resident R109 put feet down on the ground and fell to the ground. Interview conducted with the Director of Therapy, Employee E13 on December 3, 2025, at 3:00 p.m. revealed If the staff are wheeling a resident, they know they need to use the leg rests. They are always calling me asking if I know where a particular resident's leg rests are because they are always lost. They (Staff) use them when the residents go to activity or attempt to wheel them back from dining. When the surveyor asked how it can prevent the person from leaning forward and falling out of the chair the Director stated, Wearing the leg rests changes your posture and your back is now towards the back of wheelchair. Ideally it is how we fit wheelchairs, When they (residents) are in their wheelchair and the leg rests are on, it puts your legs bent and your back up and in more. Interview conducted on December 4, 2025, at 10:00 a.m. with Restorative Nursing Aide (NA), Employee E10 who was Resident R109's escort on the day of the incident. Nurse Aide, Employee E10 witnessed the resident's fall from the wheelchair. Nurse Aide, Employee E10 stated it is not unusual for Resident R109 to not use leg rests. The resident self-propels [himself/herself] around the facility. Nurse Aide, Employee E10 didn't notice if the resident had the footrest on in the lobby where she first met the resident that day. Nurse Aide, Employee E10 stated there were two transport people from an outside company, the driver, Employee E11, and Employee E12. Once the transport company reached the doctor's location, transport staff, Employee E12 got the resident out of the van and wheeled the resident towards the office. They only went 2-3 feet, and I was walking behind them when the resident fell face first on the concrete pavement. Interview the Nursing Home Administrator on December 4, 2025, at 2:00 p.m. revealed that it was the nurse aide's responsibility to ensure residents are dressed, have the proper equipment as oxygen, or leg rests before leaving the facility. But because Resident R109 always self-propelled around the facility [he/she] did not need them outside the facility. They are only to rest your legs. The NHA was unable to answer how, if the resident was being wheeled by someone else, without leg rest how long the resident was able to hold both of legs up above the ground before the resident's legs started getting tired. The NHA said it was a natural reaction that made the resident put [his/her] feet down. After Resident R109's fall, an in-service was completed by the facility staff that stated, When residents are attending an appointment assure leg rest are in place. Nursing management must visualize wheelchairs prior to leaving. The facility failed to ensure that Resident R109 was provided with the necessary equipment of leg rests to ensure safety and proper positioning during transportation to outside appointment. This failure resulted in actual harm to Resident R109 who while being wheel out of the transportation van fell out of the wheelchair and sustained a right femur fracture. 28 PA Code 201.18(b)(1) Management 28 PA Code 211.10(d) Resident Care policy 28 PA Code 211.12(d)(1)(3)(5) Nursing services		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395479	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Gwynedd Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 773 Sumneytown Pike Lansdale, PA 19446	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of facility policy, review of clinical records, and staff interviews it was determined that the facility failed to review and revise a resident care plan with new interventions status post a fall for one of 33 residents reviewed (Resident R3). Findings include: Review of facility policy Care plans, Comprehensive Person-Centered revised March 2022, revealed a comprehensive, person-centered care plan that includes measurable objectives to meet the resident's needs is developed and implemented for each resident. Assessments of residents are ongoing, and care plans are revised as information about the resident and the residents' conditions changes. The interdisciplinary team reviews and updates the care plan when there has been a significant change in the resident's condition and/or when the desired outcome is not met. Review of Resident R3's annual Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated June 27, 2025, revealed the resident had severe cognitive impairments and diagnoses of dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), muscle weakness, difficulty in walking, unspecific fall, and spinal stenosis (abnormal narrowing of the spinal canal resulting in a neurological deficit such as pain, numbness, tingling, and loss of motor control). Continued review of Resident R3's MDS revealed the resident required supervision or touching assistance with sit to stand (ability to come to a standing position from sitting in a chair, or on the side of the bed) and required supervision or touching assistance for the ability to walk at least 10 feet. Review of Resident R3's care plan dated August 10, 2023, revealed the resident demonstrated decreased ability to perform activities of daily living and required assistance with toileting. Further review of Resident R3's care plan dated August 10, 2023, revealed the resident had the potential for falls related to decreased mobility, history of falls, and poor safety awareness. The most recent care plan intervention for this focus of the care plan was added February 3, 2025, to include lab work as ordered. Review of Resident R3's clinical record revealed a nursing note dated September 19, 2025, that revealed the resident was observed on the floor in front of the bathroom door, laying on his/her sacrum and left side. The resident's wheelchair was noted by the bed on the opposite side of the room. Resident R3 reported he/she was walking to the bathroom and fell. Review of facility documentation revealed a post fall investigation dated September 19, 2025, which indicated that Resident R3 took self to the bathroom and fell. Non-skid socks were not in place and resident did not call for assistance. Resident R3 was noted to be wearing house slippers at the time of the fall. Resident R3 was subsequently transferred to the hospital and admitted with a hip fracture. Review of statement by Registered Nurse, Employee E7, revealed Resident R3 is non-complaint with call bell and uses house slippers at side of bed to self-transport to the bathroom. Review of Resident R3's clinical record and comprehensive care plan revealed no documented evidence that the facility reviewed and revised Resident R3's care plan with new interventions to address the root cause of the fall. 28 Pa. Code 211.10 (d) Resident care policies.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395479	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Gwynedd Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 773 Sumneytown Pike Lansdale, PA 19446	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on review of clinical records and facility documentation it was determined the facility failed to ensure that one resident who displayed and was diagnosed with dementia, receive the appropriate treatment and services to attain or maintain his or her highest practicable, mental, and psychosocial well-being that during care for one of 33 residents reviewed (Resident R11). Findings include: Review of Resident R11's clinical record revealed that the resident was admitted to the facility in August 2022, diagnosed with psychological disorders that included unspecified dementia, unspecified severity, with other behavioral disturbances, major depressive disorder, recurrent, severe with psychotic symptoms, unspecified dementia, unspecified severity, with other behavioral disturbances, and delusional disorder. Resident R11 was assessed as cognitively impaired, did not speak English, and spoke through a translator to communicate. Resident R11's care plan dated January 2022 revealed the resident was resistant with care and combative, known to swing arms and throw objects. Nursing interventions included, using a calm slow approach, explaining care step by step before proceeding, and if the resident became combative or resistant, nursing was to stop task and/or leave the room, allowing time to calm. Facility documentation dated March 16, 2025, revealed Resident R11 complained to the translator that the nurse aide (NA) was rough with care. The facility documentation stated that during care the resident was very agitated and was swinging her arms and intentionally striking the NA. Review of the witness statement from the NA stated that when she entered Resident R11's room the bed alarm was sounding because the resident was attempting to get out of bed. The NA stated Resident R11 was very combative, striking the NA multiple times while she attempted to wash the resident's body, the resident took the washrag and threw it across the room, and repeatedly swung her arms while the NA attempted to brush the resident's hair. On December 4, 2025, at 2:00 p.m., this was confirmed with the Nursing Home Administrator that the interventions to reduce Resident R11 combativeness were not implemented. 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(12)(3) Nursing services		