

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2025
NAME OF PROVIDER OR SUPPLIER Wyndmoor Hills Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8601 Stenton Avenue Wyndmoor, PA 19038	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview with staff and residents, and observations, it was determined that the facility did not ensure residents' received services in the facility with reasonable accommodation, needs, and preferences for two out of 17 residents reviewed (Resident R1, R2)</p> <p>Findings include:</p> <p>Review of facility policy 'Resident Rights Guidelines for All Nursing Procedures,' revised October 2010, indicates that purpose of policy is to provide general guidelines for resident rights while caring for the resident, including b. Resident dignity and respect, h. Resident freedom of choice.</p> <p>Interview with Resident R2 on Monday, February 24, 2025, at 11:30 am, indicated that residents stayed in their chairs during night shift after an emergency evacuation, during the overnight shift, from Saturday, February 22, 2025, through Sunday, February 23, 2025.</p> <p>Interview with licensed nurse, Employee E5, who worked night shift, confirmed that approximately 10 residents stayed in wheelchairs and regular chairs, during overnight shift, on Saturday, February 22, 2025, through Sunday, February 23, 2025.</p> <p>Interview with administrator from assisted living facility, on February 25, 2025, at 12:32 pm, indicated that beds for residents who were evacuated to first floor activities room, were received on Sunday morning, February 23, 2025.</p> <p>Review of facility policy 'Activities of Daily Living (ADL's), Supporting,' indicates that 2. Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing), grooming, and oral care; b. Mobility (transfer and ambulation, including walking).</p> <p>Review of facility provided shower schedules for evening shifts, indicated that Resident R1, in room [ROOM NUMBER], was scheduled for a shower on Tuesday evening shift.</p> <p>Review of Resident R1's clinical record revealed medical diagnosis of hemiplegia (paralysis) affecting left nondominant side, muscle weakness, lack of coordination, morbid obesity, contracture of left hand and left wrist.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with Resident R1, on Wednesday, February 26, 2025, at 11:17 am, revealed that he prefers shower but instead received bed-bath due to no Hoyer lift available.</p> <p>Interview with unit manager, employee E3, on Wednesday, February 26, 2025, at 11:20 am, indicated that Hoyer lift is on first floor, charging, and R1 did not have shower yesterday because of water issues.</p> <p>Findings confirmed with facility's director of nursing and administrator.</p> <p>28 Pa. Code 201.29(a) Resident Rights</p> <p>28 Pa. Code 211.10(d) Resident care policies</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical record, and staff interview, it was determined that the facility failed to ensure that pain management was provided in a timely manner to residents consistent with standards of professional practice for one of one resident reviewed for pain (Resident R18).</p> <p>Findings include:</p> <p>Review of facility policy on Pain Assessment and Management under section Purpose: The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. Under section General Guidelines: #1. The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. #2. Pain management is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. #3. Pain management is a multidisciplinary care process that includes the following: a. Assessing the potential for pain; b. Recognizing the presence of pain; c. Identifying the characteristics of pain; d. Addressing the underlying causes of the pain; e. Developing and implementing approaches to pain management; f. Identifying and using specific strategies for different levels and sources of pain; g. Monitoring for the effectiveness of interventions; and h. Modifying approaches as necessary. #5. Acute pain (or significant worsening of chronic pain) should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained.</p> <p>Review of Resident R1's clinical record revealed that Resident R18 was admitted to the facility on [DATE] with diagnoses of but not limited to Presence of Right Artificial Knee Joint, Infection and Inflammatory Reaction Due to Internal Right Knee Prosthesis, Right Knee Effusion, Acute Osteomyelitis (infection in the bone) of Ankle and Foot, Osteoarthritis (degenerative joint disease othat results from breakdown of joint caruilage and underlying bone) of the Knee, Rheumatoid Arthritis ([NAME] inflammation disorder), Chronic Pain Syndrome, Gangrene (death of body tissue due to lack of blood flow).</p> <p>Review of physician's order revealed an order for Oxycodone HCl Oral Tablet 20 milligrams (Oxycodone HCl) give 2 tablet by mouth every 4 hours as needed for severe pain with order date of February 14, 2025, and an order for Tylenol Oral Tablet 325 milligrams (Acetaminophen) give 3 tablet by mouth every 6 hours for mild pain with an order date of February 14, 2025.</p> <p>Review of Resident R18's February MAR (Medication Administration Record) revealed that, on February 22, 2025, at 12:22 pm Resident R1 had a documented pain level of 8 and received Oxycodone HCl Oral Tablet 20 MG (Oxycodone HCl) 2 tablets by mouth as needed for severe pain. This was the last documented evidence of Resident R1 receiving Oxycodone HCl Oral Tablet 20 MG (Oxycodone HCl) 2 tablets by mouth as needed for severe pain until her discharge from the facility on the evening of February 23, 2025.</p> <p>Further review of the February MAR revealed that on February 23, 2025, at 12:00pm Resident R18 had a documented pain scale was 10 and was given the standing dose of 3 tablets of Tylenol Oral Tablet 325 milligrams by mouth every 6 hours for mild pain.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further, review of Resident R18's February MAR revealed that there was no documented evidence that resident received Oxycodone HCl Oral Tablet 20 milligrams (Oxycodone HCl) 2 tablets by mouth every 4 hours as needed for severe pain at 12:00 pm when resident's pain scale was 10.</p> <p>Interview with Nurse Manager, Employee E3 conducted on February 26, 2025, at 12:48pm revealed that the facility uses the numeric pain scale (0-10) in assessing pain with 0 being no pain, 1- 4 is mild, 5-7 is moderate, 8-10 is severe.</p> <p>Observation on February 24, 2025, at 11:18am with nurse supervisor Employee E6 of the narcotic bin of the medication cart located on the first floor of the Assisted Living building where residents from the facility were evacuated to revealed that Resident R18 did not have any Oxycodone in the narcotic bin. Employee E6 then produced an intact blister pack of Oxycodone 20 mg with 30 tablets labelled with Resident R18's name with a date ordered of 2/23/2025 and date received 2/24/ 2025.</p> <p>Interview with nurse supervisor, Employee E6 conducted at the time of the observation, confirmed that Resident R18 ran out of Oxycodone and that the Oxycodone supply was ordered on February 23, 2025, and was received on February 24, 2025.</p> <p>Interview with Director of Nursing, Employee E2 and nurse supervisor, Employee E3 revealed that when there are only 8 tabs left in the blister pack, the nurses orders for additional meds. Further Employee E2 and Employee E3 stated that they ordered the Oxycodone HCl Oral Tablet 20 milligrams but the pharmacy did not deliver the medication. However, the review of the blister pack of Oxycodone 20 mg with 30 tablets labelled with Resident R18's name revealed that the Oxycodone 20 mg was ordered on February 23, 2025, and was delivered and received on February 24, 2025.</p> <p>Interview with, Employee E3 conducted on February 26, 2025, at 12:48pm revealed that on February 23, 2025, she was requested to go with Nurse Supervisor Employee E6 to the building to co-sign the pulling of Oxycodone 40 mg from the Pyxis (a secure machine that stores and dispenses medications) for Resident R18 who was complaining of severe pain because Resident R18 had ran out of her Oxycodone. Employee E3 did not remember the time when she went with Employee E6 into building.</p> <p>Further interview with Employee E3 revealed that on February 23, 2025 (Employee E3 did not remember the time) Employee E3 and Employee E6 went into the facility assessed the Pyxis Machine and pulled Oxycodone 40 mg. Further, Employee E3 revealed that Employee E6 then took the Oxycodone back to the Assisted Living building.</p> <p>Further interview with Nurse Manager Employee E3 conducted on February 26, 2025, confirmed that there was no documented evidence that the Oxycodone 40 mg was administered to Resident R18. Employee E3 then attempted to call Employee E6 to clarify what happened and for an interview surveyor but there was no answer. Employee E6 was not available for interview.</p> <p>Further interview with Employee E3 revealed that licensed nurse Employee E7 was assigned to give the medications and that Employee E7 must have given the Oxycodone to Resident R18 and just forgot to sign it.</p> <p>Licensed nurse Employee E7 was not available for interview.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with DON Employee E2 conducted on February 26, 2025, at 1:15 pm revealed that according to the Pyxis record, the Oxycodone was pulled by Employee E3 and Employee E6 on February 23, 2025, at 2:10 pm.</p> <p>28 Pa. Code 211.9 (a)(1) Pharmacy services.</p> <p>28 Pa. Code 211.12 (d)(5) Nursing services.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on review of facility policy, observation, and staff interview, it was determined that the facility failed to ensure that drugs ad biologicals are stored in a safe/secure environment in accordance with professional standards for two large tranparent plastic garbage bags containing blister packs of medications.</p> <p>Findings include:</p> <p>Review of undated facility Policy on Storage of Medication revealed that under section Policy Statement: The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Under section Policy Interpretation and Implementation #1. Drugs and biologicals used in the facility are stored in locked compartments or room, #3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. #11. Only persons authorized to prepare and administer medications have access to locked medications.</p> <p>Observation conducted on February 24, 2025, at 9:40am together with DON (Director of Nursing) Employee E2 of the first floor of the Assisted Living Facility where some of the residents from Wyndmoor Hills Rehabilitation and Nursing Center were housed after the facility was evacuated on February 22, 2025 revealed that two unattended large transparent plastic garbage bags filled with blister packs of medications was on the floor in the hallway outside the activity room used as the resident's sleeping area.</p> <p>Interview with Employee E2 conducted at the time of the observation confirmed that two large transparent plastic garbage bags filled with blister packs of medications was on the floor in the hallway outside the activity room used as the resident's sleeping area was left unattended.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code. 211.12(c)(d)(1) Nursing services</p>		