

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 05/29/2025
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on review of facility policy, resident's clinical record , observation and interview with staff, it was determined that the facility failed to ensure the safety of the resident's environment related to medication left at the bedside for one of ten residents reviewed. (Resident R2)</p> <p>Findings include:</p> <p>Review of facility policy titled Administrating Medications revised December 2012. revealed that medications shall be administered in a safe and timely manner and as prescribed. Medications must be administered within one hour or prescribed time and the individual administering the medications must verify the resident's identity before giving his or her medications. If a drug is withheld, refused or given at a time other than scheduled time the individual administering the medication shall initial and circle the mar (medication administration record) space provided for that drug induce as required or indicated for the medication the individual administering the medication will record in the resident's medical record the date and time the medication was administered, the dosage, the root of administration, any complaints or symptoms, any results achieved and when those results were observed and the signature entitled the person administering the drug. Residents may self administer their own medications only if the attending physician in conjunction with the inner disciplinary care planning team, has determined that they have the decision making capacity to do so safely .</p> <p>Review of Resident R2's admission Minimum Data Set (MDS- a federal mandated assessment tool for all residents) dated April 7, 2025, revealed Resident R2 was admitted into the facility on April 7 2025, from the hospital with diagnosis including heart failure (the heart cannot pump enough blood), hypertension (high blood pressure), renal failure (the kidneys loses the ability to remove waste and balance fluids), diabetes (a disease characterized by elevated levels of blood glucose), cerebral vascular accident(stroke), and seizure disorder requiring medications such as antipsychotics, anticoagulant s(blood thinner), anti convulsive(seizure preventative) and insulin (regulates blood sugar). Further review of this resident's MDS revealed the resident has a cognition BIMS (brief interview of mental status) score of 15 indicating that Resident R2's cognition was intact.</p> <p>Observation of Resident R2 on May 29, 2025 at 11:10a.m. revealed a medication cup consisting of nine pills set on the resident's bedside table.</p> <p>Interview with the Director of Nursing, Employee E2, at the time of the above observation confirmed that the medication cup was left on the bedside table, which is not facility policy and an inappropriate administration of medication for a resident without order to self administer medication.</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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NAME OF PROVIDER OR SUPPLIER Wyndmoor Hills Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8601 Stenton Avenue Wyndmoor, PA 19038	

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa Code 211 .10 (c) Resident care policies</p> <p>28 Pa Code 211.12 (d)(1)(3)(5) Nursing services</p>

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or get specialized rehabilitative services as required for a resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, clinical record and staff and family interview, it was determined that the facility failed to ensure that rehabilitation services were provided timely for one of ten residents reviewed. (Resident R1)</p> <p>Findings include:</p> <p>Review of Resident R1's clinical record revealed that the resident was admitted to the facility on [DATE].</p> <p>Interview with Resident R1's family member on May 29, 2025 at 10:40 a.m. revealed that the resident entered the facility following knee surgery, and the resident arrived to the facility at approximately 6:00 pm. The resident's family member stated that her surgeon wanted her to be ambulating as soon as possible, it would benefit her recovery . Resident R1 was placed into bed and told she cannot get out of the bed until assessed by physical therapy. Resident R1 requested assistance to the lavatory but was told she needed to use a bed pan or brief until she was seen and assessed by physical therapy. Resident R1's family asked staff when she could be seen and was told its the weekend not until Monday.</p> <p>Interview with Social Worker, Employee E7 revealed that she was aware that the family was not satisfied with the level of care in the facility, the resident was not assessed by physical therapy and this employee could not reach anyone in the physical therapy department to request a consult, and was unsure when the resident would be assessed. Employee E7 tried to transfer the resident to another facility but was unable due to weekend hours.</p> <p>Interview with Physical Therapy Director, Employee E5 on May 29, 2025 at 1:40 p.m. revealed that Resident R1 entered the facility on Friday May 16, 2025 and was scheduled to see physical therapy on Sunday May 18, 2025. This employee confirmed that the physical therapy department was short staffed that weekend and had no therapist available on Saturday May 17, 2025. Further interview with Employee E5 confirmed that the Resident R1 no being able to get out of the bed was inappropriate, and that the nursing staff was responsible to do the assessment for resident to be able to ambulate.</p> <p>Interview with Licensed nurse, Employee E6 on May 29, 2025 at 2:00 p.m. revealed that she believed that the physical therapy team needs to assess the residents to determine the appropriate level of care needed to transfer and ambulate.</p> <p>Interview with NHA, Employee E1 on May 29, 2025 at 3:40p.m. confirmed there is a breakdown of communication of responsibilities between physical therapy and nursing staff.</p> <p>28 Pa. code 211.12(a)(c)(d)(3) Nursing services</p> <p>28 Pa. Code 201.18 (b)(1) Management</p>		