STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396115	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wyndmoor Hills Rehabilitation and Nursing Center	8601 Stenton Avenue Wyndmoor, PA 19038

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Findings include:Review of facility policy 'Comprehensive person-centered care plans ' revised December 2016, indicates that Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. Review of Resident R1's admission interim care plan, completed on August 18, 2025, at 3:06 pm, indicated the resident was incontinent of bowel and bladder. The resident required total dependance for personal hygiene, toilet use and bathing.Review of R1's care plan revealed no evidence of goals or interventions related to incontinence care. Review of Resident R6's clinical record revealed that at times, the resident required substantial/maximal assistance with toileting hygiene and was dependent: helper does all of the effort. Resident does none of the effort to complete activity. Or, the assistance of two or more helpers is required for the resident to complete the activity.Further review of Resident R6 's clinical record revealed that at times, she was incontinent of bowel and bladder.Review of Resident R6's care plan indicates no evidence of goals or interventions related to incontinence care.Review of Resident R7 's ' functional abilities and goals - admission, ' completed on October 13, 2025 at 6:29 pm, indicated the resident she required substantial/maximal assistance with toileting hygiene; further review of clinical record revealed the resident was incontinent of bladder function.Review of Resident R7 's care plan revealed no evidence of goals or interventions related to incontinence care. Review of Resident R8 's 'interim care plan' completed on October 22, 2025 at 9:27 pm, revealed the resident required total dependance for personal hygiene, toilet use, and was incontinent of bladder and bowel function.Review of Resident R8 's care plan revealed no evidence of goals or interventions related to incontinence care.Review of Resident R9's ' functional abilities and goals - admission, 'completed on October 25, 2025, at 12:35 pm, revealed the resident was dependent for toileting hygiene; further review of clinical record revealed Resident R9 was incontinent of bladder function.Review of Resident R9 's care plan revealed no evidence of goals or interventions related to incontinence care.Interview with Nursing Home Administrator and Director of Nursing on October 29, 2025 at 2:30 pm confirmed the above findings.28 Pa Code 211.10(d) Resident Care Policies

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and clinical record review, it was determined that the facility did not ensure the comprehensive care plan was implemented related to wound care for three of twenty residents reviewed (Resident R1, R4, R5). Finding Include: Review of Resident R1's clinical record revealed that Resident R1 was admitted to the facility on [DATE] with diagnoses of Dementia (irreversible, progressive degenrative disease of the brain). Further Review of Resident R1's clinical record revealed resident was seen by podiatry for follow-up on September 10, 2025 and findings included dry gangrenous changes on right toe related to peripheral vascular disease. Podiatry recommendations included Apply betadine and gauze to right hallux (great toe) daily. Monitor toe for worsening gangrene, redness, swelling and color. Take measurements of gangrene daily and record. Review of Resident R1's clinical record revealed resident was seen by podiatry on September 26, 2025 for the removal of ingrown toenails on left and right foot. Further review revealed that podiatry ordered Continue antibiotics. Leave dressing on for 24 hours. After removal bathe like normal, dry area, apply topical antibiotic ointment and band aid until next follow up. Review of Resident R1's care plan on October 15, 2025 revealed no care plan in place for wound care. Interview with Employee E2, Director of Nursing on October 16, 2025 at 12:00pm confirmed no care plan in place for resident's foot care or wound care. Review of Resident R4's clinical record revealed the resident was admitted to the facility on [DATE]. The resident had the following diagnoses: Unspecified Dementia with behavioral disturbances with a date of June 27, 2025. Review of Resident R4's current care plan revealed the resident did not have a care plan in place for Dementia.Review of Resident R5's clinical record revealed the resident was admitted to the facility on [DATE]. The resident had the following diagnosis: bipolar disorder (a chronic mental health condition characterized by extreme mood swings between mania and depression).Review of resident R5 's care plan revealed the resident did not have a care plan in place for bipolar disorder.28 Pa. Code 211.12(d)(3) Nursing services.28 Pa. Code 211.12(d)(5) Nursing services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on a review of clinical records, facility policy, observations, and staff interview, it was determined the facility failed to ensure resident environment was free from potential accident hazards for one of two nursing units observed (third floor). Findings include:Facility policy titled Storage of Medication revised 2023, revealed the facility stores all drugs and biologicals in a safe, secure, and orderly manner. Drugs and biologicals used in the facility are stored in locked compartments or room. The nursing staff is responsible for maintaining medication storage and unlocked medication carts are not to be left unattended. During an observation on October 14, 2025 at 11:17 a.m. on the third floor revealed 12 blister packs of medication left unattended on the medication cart outside of the nurse's station. Several residents were observed sitting near the unattended medication cart. Further observation on October 14, 2025 at 11:20 a.m. revealed the third floor medication storage room was propped open with an ointment bottle. Inside the medication room the medication was observed to have injectable medications and vials of insulin. Interview on October 14, 2025 at 11:25 a.m. with Employee E4, Licensed Practical Nurse, confirmed the 12 blister packs of medication on the medication cart should be locked and stored away from resident access and the medication storage room should be locked to restrict resident access. 28 Pa. Code 201.18 (b)(1) Management.28 Pa. Code 211.10 (c) Resident care policies.28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Findings Include:Review of requested staff training files revealed three of the employees reviewed should have a yearly evaluation. A request was made for Employee E9, E10, and E11's yearly reviews.Interview with the Human Resources Director Employee E6 on October 16, 2025 at 10:30 a.m. revealed she was still looking for the yearly reviews.Review of facility documentation revealed Employee E9 was hired on June 22, 2021 as a full-time employee. Employee E10 was hired as a part-time employee on October 12, 2023, and Employee E11 was hired as per necessary on March 2, 2023.After giving further time to locate the yearly reviews, on October 17, 2025 2:13 p.m. Employee E2 the Director of Nursing revealed they were not able to find the annual reviews for the three nurse aides requested.28 Pa. Code 201.18(b)(1)(3) Management28 Pa. 211.12(c) Nursing services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical records review, facility investigations and staff interview, it was determined that the facility failed to maintain accurate records regarding wound care and nutritional intake for three of 24 residents reviewed. (Resident R1, R2 and R3) Findings include:Review of facility policy, titled Advance Directives dated March 17, 2025 states, Policy Statement- Advance directives will be respected in accordance with state law and facility policy. Further review of the facility policy reads, 10. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directiveReview of Resident R3's clinical record revealed the resident was re-admitted to the facility on [DATE] with the diagnsoses of Heart Failure (a condition where the heart muscle cannot pump blood effectively), Muscle Weakness, and Dysphagia (difficulty or discomfort swallowing).Review of Resident R3's electronic medical record revealed a physician order dated September 16, 2025 listed as Full Code, that indicated the resident's code status was a CPR/Attempt Resuscitation (Cardiopulmonary Resuscitation (CPR) is an emergency procedure consisting of chest compressions often combined with artificial ventilation in an effort to manually preserve intact brain function until further measures are taken to restore spontaneous blood circulation and breathing in a person who is in cardiac arrest).Further review of Resident R3's electronic medical record revealed a form, Physician Orders for Life Sustaining Treatment (POLST), dated and signed by the facility social worker Employee E7 on September 25, 2025, that specified the resident's code status was Do Not Resuscitate (DNR - allow natural death if resident found with no pulse and is not breathing).Interview with the social worker Employee E7 on October 16, 2025 at 11:33 a.m. revealed Resident R3 did have a care plan meeting held and that was when the discussion came up and the resident ' s POLST form was changed.Interview with the Director of Nursing Employee E2 on October 16, 2025 at 2:37 p.m. revealed the responsibility would fall on the director of nursing Employee E2 to complete the POLST review and update the order in the electronic system. Employee E2 confirmed the POLST form did not accurately reflect the physician order for code status on Resident R3's electronic medical record. Review of Resident R1's clinical record revealed that Resident R1 was admitted to the facility on [DATE] with diagnoses of Dementia. Review of Resident R1's clinical record revealed a physician order dated September 1, 2025 to Cleanse B/L (Bilateral) Hallux (big toe) ingrown toenails, then apply topical antibiotic ointment to affected area, cover with band-aid every day shift. Review of Resident R1's September 2025 Treament Adminsitration Record revealed that the above stated treatment was documented as completed on September 8, 2025 Review of documentation of an investigation conducted by the facility as result of a concern presented by Resident R1's family member revealed that licensed nurse, Employee E12, failed to complete wound treatment to the resident left foot on September 8, 2025 as ordered by physician. Interview with Employee E2, Director of Nursing on October 16, 2025 at 1:30pm, revealed that dressing on resident's left foot, upon dressing change on September 8, 2025, was dated September 5, 2025. Employee E2, Director of Nursing confirmed that dressing changes were marked as completed in Resident R1's medical record daily between September 5, 2025 through September 8, 2025 but per the date on the dressing the last treatment was September 5, 2025. Review of Resident R2's clinical record revealed that Resident R2 was admitted to the facility on [DATE], with diagnosis of, Chronic Kidney Disease, Dementia. Review of Resident R1's clinical record revealed significant weight loss. September 25, 2025- 109lbsOctober 6, 2025- 106 lbs October 14, 2025- 100.5 lbs Review of Employee E13, Registered Dietician's note dated October 14, 2025 revealed BMI 18.6, very underweight. Patient showing 6. 9% weight loss from 9/25/25- 10/7/2025. Intake per nursing variable but average between 50-60%. Observation of dining room on October 14, 2025 at 12:30pm revealed Resident R2 encouraged by Employee E14, Nursing Assistant to eat multiple items on plate and offering alternatives. Resident refused to eat and spit out food. Interview with Employee E14, Nursing assistant on October 14, 2025 at 12:30 pm revealed Resident R2 refuses to eat anything, even with encouragement it is very difficult to get resident to eat. Review of Resident R1's clinical record revealed that Resident R2 ' s intake on October 14, 2025 at 2:45pm was recorded as having eaten 75-100% of his/her meal. Interview with Employee E15, Nurse Assistant on October 16, 2025 at 11:00 am revealed that Resident R1 had only consumed approximately 30% of her breakfast on October 16, 2025. Review of Resident R1's clinical record revealed that Resident R2 ' s intake on October 16, 2025 at 9:56am was recorded as having eaten 75-100% of his/her meal. 28 Pa. Code 201. 18(b)(2) Management28 Pa. Code 211.12(d)(1) Nursing services