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	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wyndmoor Hills Rehabilitation and Nursing Center	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)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, facility policy, clinical records and staff interviews, it was determined that the facility failed to ensure an appropriate, safe, and properly documented discharge process for 1 of 15 residents reviewed (Resident R1).Findings include:Review of undated facility policy titled Intravenous Therapy Policy, revealed the policy is intended to ensure the safe administration, monitoring, and management of intravenous (IV) therapy for residents requiring hydration, medication administration, blood products, or other physician-ordered IV treatments.Review of Resident R1's medical record revealed the resident was admitted to the facility on [DATE], with admitting diagnosis of sepsis (body's extreme response to an infection) due to methicillin susceptible staphylococcus aureus (type of bacteria).Review of Resident R1's medical record revealed a physician order dated May 11, 2026, for Cefazolin Sodium Injection Solution Reconstituted (intravenous antibiotic) administer 2 grams every 8 hours for 37 days for post operative hip surgery.Further review of Resident R1's medical record revealed a physician order written on May 11, 2026, at 21:43 (9:43 p.m.) to transport patient back to hospital for IV antibiotic therapy.Interview on June 9, 2026, at 1:30 p.m. with the Nursing Home Administrator, Employee E1, and Director of Nursing, Employee E2, revealed Resident R1 was discharged because after Resident R1 was admitted , it was discovered that the resident was a Level 3 sex offender under Megan's Law. Nursing Home Administrator, Employee E1, and Director of Nursing, Employee E2, reported that the facility could not have Resident R1 living at the facility for fear that he/she may display inappropriate behaviors. Electronic communication with the Director of Nursing (DON), Employee E2, on June 10, 2026, at 11:52 a.m. confirmed that the facility does accept residents for IV antibiotic treatment.Review of Resident R1's nursing progress notes revealed no documentation on behaviors.During a telephone interview on June 12, 2026, at 3:09 p.m. the Nursing Home Administrator, Employee E1, and Director of Nursing, Employee E2, were made aware that Resident R2's discharge was not appropriate as the facility accepts residents with IV therapy orders and Resident R2 had no documented behaviors that would be deemed inappropriate for this population.28 Pa. Code 201.14(a) Responsibility of Licensee28 Pa. Code 201.18 (1)(e) Management

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396115	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wyndmoor Hills Rehabilitation and Nursing Center	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)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on a review of facility policies, facility documentation, clinical record reviews and interviews with residents and staff, it was determined that the facility failed to ensure that residents remained free from significant medication errors for one of 15 residents reviewed (Resident R2).Findings include: Review of the undated facility policy titled, Administering Medications states, Medications shall be administered in a safe and timely manner, and as prescribed. Interview on June 9, 2026, at 1:05 p.m. with Resident R2 revealed that she was admitted to the facility on Friday, May 29, 2026, by ambulance from the hospital. She said that the ambulance driver gave her a big envelope packet of papers which she did not read but gave it to the nurse. The resident stated that she was concerned about staff asking her to check her blood glucose level several times. The resident also stated that she told them staff that she was not diabetic, but that they insisted. Continue interview with Resident R2 revealed that staff gave her shots in her stomach and lift a little blue mark. When asked the surveyor asked if this was from the insulin she said, I guess so. When asked what the shots were she said she remembered that one was heparin, which she did not remember getting in the hospital. She said that they finally listened to her the next day when she refused to allow the finger stick to check her blood glucose. Resident R2 stated that they came back and told her about the medication error that had occurred with the paperwork from the hospital being for someone else. Review of resident R2's medical record revealed a Medication Administration Report for May 2026, which revealed that Resident R2 received the following medications: May 29, 2026 at 1600 (4:00 p.m.) insulin lispro inject subcutaneous (under the skin) for type 2 diabetes (chronic condition characterized by insulin resistance and high blood sugar levels, often manageable through lifestyle changes and medication) 6 units with a corresponding blood sugar of 104.May 29, 2026 at 2100 (9:00 p.m.) insulin glargine inject 26 units subcutaneously at bedtime for type 2 diabetes.May 29, 2026 at 2200 (10:00 p.m.) inject Heparin Sodium (Porcine) Solution 5000 UNIT/ML subcutaneously every 8 hours for DVT (deep venous thrombosis is a blood clot (thrombus) that forms inside deep veins in your legs or pelvis). A corresponding warning note was automatically transcribed in the progress notes for Resident R2 as follows: Note Text : The order you have entered Heparin Sodium (Porcine) Injection Solution 5000 UNIT/ML (Heparin Sodium Porcine) Inject 1 ml subcutaneously every 8 hours for dvt until 06/15/2026 23:59, Has triggered the following drug protocol alerts/warning(s): Drug to Drug Interaction, The system has identified a possible drug interaction with the following orders: Aspirin Oral Tablet Chewable 81 MG Give 1 tablet by mouth one time a day for stroke prevention. Severity: Severe Interaction: Aspirin may enhance the anticoagulant effect of heparin. Clopidogrel Bisulfate Oral Tablet 75 MG Give 1 tablet by mouth one time a day for stroke until 05/31/2026 15:00, Severity: Severe Interaction: Clopidogrel Bisulfate Oral Tablet 75 MG may enhance the anticoagulant effect of heparin. Further review of Resident R2's clinical record revealed that the resident did not have diabetes, not type 1 or type 2 diabetes. A review of the physician orders revealed that on May 29, 2026, the following orders were entered for Resident R2: Aspirin 81 mg oral tablet once a day for stroke prevention. Clopidogrel bisulfate 75 mg oral tablet give one time a day for stroke prevention. Heparin Sodium (Porcine) Injection Solution 5000 UNIT/ML, Inject 1 ml subcutaneously every 8 hours for DVT. The administration of these medications to Resident R2, together with the administration of insulin causing possible low blood sugar reaction and the heparin having a synergistic reaction with the aspirin and Clopidogrel increase the risk of hemorrhage. Interview with the Director of Nursing on June 9, 2026, at 1:25 p.m. confirmed that some of Resident R2's medications were entered in error due to paperwork from the hospital with another resident's name and medication list. The facility did not notice the name was different on the medication list until May 30, 2026, when the nurse on duty, Employee E8, went to the supervisor, Employee E7, stating that Resident R2 was refusing a blood sugar test insisting that she was not diabetic. The supervisor investigated and found that the insulin and heparin were on a sheet from the hospital with another resident's name on the paperwork. (continued on next page)

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	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wyndmoor Hills Rehabilitation and Nursing Center	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)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Nursing Supervisor, Employee E7, confirmed that he had found the mistake noticing the wrong name on the one hospital sheet, and that the resident was assessed and the physician and resident were notified of the mistake. Review of the paperwork from the hospital that was entered into Resident R2's orders confirmed that it was for another resident who was also discharged from the hospital on the same day. Review of statements taken during the investigation into Resident R2's significant medication error revealed a statement from the Registered nurse on duty, Employee E9, on May 29, 2026, who stated that she helped the unit manager to enter the medications into the system. A statement from the Unit manager, Employee E10, confirmed that Employee E9 helped her enter the medications from the hospital recommendations. A statement from Licensed nurse, Employee E8, confirmed that he was attempting to take a blood sugar test from Resident R2 when she refused and that he went to the charge nurse and supervisor, Employee E7 who then found the significant medication error. 28 Pa Code 211.12(d)(1) Nursing services 28 Pa Code 211.12(d)(5) Nursing services

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	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wyndmoor Hills Rehabilitation and Nursing Center	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)
F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, and a review of clinical records, it was determined that the facility failed to ensure full visual privacy for one of 15 residents reviewed (Resident R9).Findings include:Clinical record review revealed Resident R9 was admitted to the facility on [DATE], with diagnoses that include hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side), affecting the right dominant side.Observation of Resident R9 in his/her room (room [ROOM NUMBER]) on June 9, 2026, at 11:35 a.m. revealed there was no privacy curtain extending around the toilet and sink (which was not in a separate room). Further observation revealed a metal track on the ceiling extending around the toilet area with empty metal clips hanging down, but no privacy curtain. Anyone entering room [ROOM NUMBER] has full view of the toilet, preventing full visual privacy.Interview with Resident R9 on June 9, 2026, at 12:25 p.m. revealed the resident was embarrassed about using the toilet for fear that someone would come in while using the toilet. Resident R9 stated that there has been no privacy curtain since his/her admission on [DATE]. Interviewon June 9, 2026, at 12:28 p.m. with Nurse Aide, Employee E5, confirmed that there was no privacy curtain around Resident R9's toilet area.Interview on June 9, 2026, at 12:30p.m. with Assistant Administrator, Employee E4, confirmed that Resident R9's privacy curtain was missing and that there should be a privacy curtain around the toilet area for privacy.The above findings were discussed with the Nursing Home Administrator, Employee E1, on June 9, 2026, at 12:35 p.m. regarding the missing privacy curtain preventing full visual privacy for Resident R9.28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.29(j) Resident rights

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	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wyndmoor Hills Rehabilitation and Nursing Center	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)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of facility documentation, observations, and interviews, it was determined that the facility failed to maintain an effective pest control program. Findings include: A review of the facility policy Pest Control revised January 2026, revealed the purpose of this policy is to prevent and control the entrance of pests and eradicate infestations. Windows, doors and exterior walls are sealed to prevent easy entrance of pests. Observation in room [ROOM NUMBER] on June 9, 2026, at 12:05 p.m. revealed multiple live roaches crawling inside the trash can between Resident R4's bed and toilet. Interview with Resident R4 on June 9, 2026, at 12:05 p.m. revealed the resident sees roaches all the time including in the dresser drawers. Resident R1 was not surprised about the live roaches in the trash can. Resident R1 reported that the Nursing Home Administrator, Employee E1, comes in his/her room [room [ROOM NUMBER]] and kills the roaches all the time. Interview with the Director of Nursing, Employee E2, in room [ROOM NUMBER] at 12:20 p.m. confirmed the live roaches crawling on the floor. Interview on June 9, 2026, at 12:02 p.m. with Resident R3 in room [ROOM NUMBER] revealed that roaches and mice are a problem. Resident R3 was observed to be cleaning up the room which was piled with stacks of used paper products. Resident R3 claims to keep these stacks of used paper products to recycles these products and makes items such as a fan made from used plastic food wrappers. Interview on June 9, 2026, at 12:09 p.m. with Resident R5 revealed that he/she sees roaches all the time and pointed at the sticky glue traps located between the bed and nightstand, and one in the corner of the room. Observation of both white glue boards revealed that they were covered with ten to twenty roaches each. Observation in room [ROOM NUMBER] on June 9, 2026, at 12:15 p.m. revealed that the window was open. Window observed to be pushed open with no screen. Observation in room [ROOM NUMBER] on June 9, 2026, at 12:25 p.m. revealed that Resident R9 window was open. Window observed to be pushed open with no screen. Observation in room [ROOM NUMBER] on June 9, 2026, at 12:15 p.m. revealed that the window was open. Window observed to be pushed open with no screen. A review of the pest control company's reports revealed the following concerns: March 9, 2026, Invoice 572775 - inspect & treat room [ROOM NUMBER], 331 for roach activity.March 16, 2026, Invoice 572776 - inspect & treat first floor breakroom for roach activity.March 23, 2026, Invoice 572777 - inspect & treat 2nd floor pantry for roach activity.April 13, 2026, Invoice 577537 - inspect & treat room [ROOM NUMBER], 225 (verbal report), lobby for roach activity.April 20, 2026, Invoice 577538 - inspect & treat 2nd fl nurse station for roach activity.April 27, 2026, Invoice 577539 - could not treat room [ROOM NUMBER] for roach activity resident changing.May 11, 2026, Invoice 582857 - inspect & treat room [ROOM NUMBER], 2nd fl nurse station for roach activity.May 18, 2026, Invoice 582858 - inspect & treat room [ROOM NUMBER] for roach activity, could not treat room [ROOM NUMBER] for roach activity due to sign on door contact precautions.May 26, 2026, Invoice 582859 - observed a few baby roaches in the pantry cabinets on the 2nd floor at the time of service. Observed a few baby roaches in the pantry cabinets on the 2nd floor at the time of service. Recommend improving sanitation habits throughout the nurse station and pantry area.May 26, 2026, Invoice 587200 - inspected and treated room [ROOM NUMBER] for roaches. Baited voids throughout. Baited cabinets, nightstand and placed insect monitors throughout. Excessive roach activity observed in the nightstand and dresser at the time of service. An interview on June 9, 2026, at 2:30 p.m. with the Nursing Home Administrator, Employee E1, and Director of Nursing, Employee E2, confirmed the above observations and stated that the pest control company comes once a week. 28 Pa. Code 201.14 (a) Responsibility of licensee.