STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395380	A. BLDG: 00 B. WING:	12/03/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SAUNDERS NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **190402**	**100 LANCASTER AVENUE** **WYNNEWOOD, PA 19096**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on an Abbreviated Survey in response to two complaints completed on December 3, 2024, it was determined that Saunders Nursing and Rehabilitation Center was not in compliance with the following Requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations related to the health portion of the survey process.	F 0000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0565 SS=D	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the	F 0565	The facility cannot go back retroactively to correct this issue. A Resident Council meeting was held on 12/20/2024 and concerns voiced were documented and acted upon promptly with a resolution. Resolutions will be reported to the individuals voicing concerns. The Interdisciplinary Team was educated by the Regional Nurse on the Resident Council process and acting upon any concerns in a timely manner as well as communicating actions taken to resolve those concerns. The NHA/designee will audit Resident Council Meeting minutes monthly to ensure any concerns voiced are acted upon promptly. Audits will be done monthly x 3 months. Results of the audits will be submitted to the quality assurance committee to determine if further action is needed.	Completion Date: **02/01/2025** Status: **APPROVED** Date: **12/23/2024**

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F 0565 SS=D	Continued from page 2 facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by:	F 0565		

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F 0565 SS=D	Continued from page 3 Based on interviews from staff and residents, and review of facility documentation, it was determined that the facility failed to act promptly upon resident grievances and recommendations, which included concerns related to the dietary department for 3 out of 3 months reviewed (September 2024, October 2024 and November 2024). Findings include: Review of the policy, "Resident Council Meeting, "with a revision date of March 2023, indicated that the role of the resident council is to improve residents quality of life, increase resident life satisfaction, and	F 0565		

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F 0565 SS=D	Continued from page 4 residents input into their daily life in a facility. The policy stated that the resident council governing body works closely with the administration of the facility and other staff to possible [sic] affect changes and resolve problems within the facility where they reside. Continued review of the policy also indicated that the meeting may be coordinated by the Activity or Social Services Directors, in conjunction with the resident council officers." "Procedures" of the resident council meetings include, but are not limited to, providing a private location for residents, having a monthly meeting schedule .... sending invitations to the	F 0565		

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F 0565 SS=D	Continued from page 5 ombudsman... ensuring that non-members and facility staff members' attendance is approved by the resident council members... the use of an agenda to provide structure. Continued review of the policy indicated that the "Procedures" for conducting the resident council meeting also include ensuring that residents are encouraged to lead discussions and generate ideas, requests and concerns, follow up on concerns... review of the previous month's meeting minutes and previous concerns and resolutions. Review of resident council meeting minutes dated September 25, 2024 indicated that there were 8 residents	F 0565		

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F 0565 SS=D	Continued from page 6 in attendance at the meeting. Continued review of the meeting minutes indicated that residents at the meeting expressed requests, concerns, and made comments regarding various departments, including the dietary department, in which "several residents reporting that the food in the dining room is cold at times. Review of resident council meeting minutes dated October 30, 2024 indicated that 14 residents were in attendance at the meeting. Continued review of the meeting minutes indicated that residents at the meeting expressed requests, concerns, and made comments regarding various department, including the dietary	F 0565		

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F 0565 SS=D	Continued from page 7 department, in which "residents stated that they have arranged a separate meeting with the administrator in regard to dining services." Review of interviews conducted individually for the November 2024 resident council meeting indicated that on November 27, 2024 residents expressed request, concerns, and made comments regarding various departments which also included the dietary department. Resident R5 reported "the food needed to be improved." Resident R9 reported "the food is often cold" and "they often run out of coffee." Resident R7 reported "food is not hot," "can't eat cold eggs," "dinners are cold to[sic],	F 0565		

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F 0565 SS=D	Continued from page 8 "has to change up dishwater." Resident R6 reported, "cold food burned food." Review of the meeting minutes from September -November 2024 did not show any evidence of how the facility responded to resident's grievances regarding various departments, including the above referenced concerns related to the Dietary Department. During an interview with Resident R7 on December 2, 2024, at 3:11 p.m. the resident reported that a group of residents had a meeting with the Nursing Home Administrator (NHA) a few weeks ago about "cold food"	F 0565		

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F 0565 SS=D	Continued from page 9 and other issues concerning the Dietary Department. Another resident (Resident R8) organized the meeting due to "ongoing issues" for months and not resolved by the NHA and the Dietary Director when it was discussed at various resident council meetings. During an interview with Resident R9 on December 3, 2024 at 12:04 p.m. Resident R9 reported that the food that she has been served was cold. Resident R9 reported that her coffee was always cold, and spoke of a time when she was served cold french fries and a cold hamburger. Resident R9 also reported that a meeting was held "a few weeks ago" with the NHA to	F 0565		

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F 0565 SS=D	Continued from page 10 discuss concerns with the food and other issues related to dining that has been discussed "for months," and not resolved. During an interview with Resident R5 on December 3, 2024 at 11:20 a.m. Resident R5 reported that any food that she is served is cold. She reported, I would love to have hot food." Resident R5 reported that people have reported cold food at meetings, but nothing has been done about it because the food is still cold. During an interview with Resident R8 on December 3, 2024 at 7:00 p.m, the resident reported that she organized the meeting that was held on	F 0565		

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F 0565 SS=D	Continued from page 11 November 14, 2024 with the NHA and other residents regarding concerns related cold food and other issues regarding their dining experience at the facility. Resident R8 reported that the concern regarding cold food had been brought up several times in various resident council meetings over the months, but reported, "we were never updated on what was being done about it, and the food continues to be cold. Cold food is not ok." During an interview with the Nursing Home Administrator (NHA) and the Food Service Director on December 2, 2024, at 2:45 p.m. it was discussed that no information could be found to	F 0565		

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F 0565 SS=D	Continued from page 12 review how resident concerns expressed during the resident council meetings from September 2024 through November 2024, and the November 14, 2024 meeting were resolved. During an interview on December 2, 2024, at 4:50 p.m. the NHA, he confirmed that he attended above referenced meeting that the residents reported that they requested that they have with him. The NHA reported that the meeting was held on November 14, 2024 regarding dining concerns, which included cold food. The NHA reported knowledge of knowing that the heating device that is used to warm that pallet that helps	F 0565		

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F 0565 SS=D	Continued from page 13 keep the food warm while being transported to residents needed to be replaced for quite some time, but has not been replaced by the facility. The facility failed to act promptly upon resident grievances and recommendations during monthly resident group meetings, which included ongoing concerns related to cold food. 28 Pa. Code 201.18 (b)(1)(3)(2.1)(4) Management 28 Pa. Code 201.29 (a) Resident Rights	F 0565		

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F 0585 SS=E	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of	F 0585	The facility cannot go back retroactively to correct this issue. The NHA/designee conducted an audit of the last 2 weeks of grievances to ensure grievances are investigated and resolved. The Interdisciplinary Team was educated on the grievance policy by the Regional Nurse. The NHA/designee will audit grievances to ensure grievances are investigated and resolved. Audits will be done weekly x 4 weeks then monthly x 2 months. Results of these audits will be submitted to the Quality Assurance Committee to determine if further action is needed.	Completion Date: **02/01/2025** Status: **APPROVED** Date: **12/23/2024**

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F 0585 SS=E	Continued from page 15 the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or	F 0585		

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F 0585 SS=E	Continued from page 16 conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by:	F 0585		

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F 0585 SS=E	Continued from page 17 Based on staff interviews, and review of facility documentation, it was determined that the facility failed to ensure that resident grievances were investigated and resolved for 3 of 3 residents reviewed. (Resident R12 R15 and R14) Findings include: Review of the facility policy, "Grievances," with a revision date of November 2022 indicated that upon receipt of a written grievance/concern form, the grievance official or designee will forward the concern form to the appropriate department for investigation, and the investigating department will submit a written report of findings and resolutions to grievance officials. Continued review of the policy indicated	F 0585		

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	395380	A. BLDG: __00_____ B. WING: _____	12/03/2024

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F 0585 SS=E	Continued from page 18 that grievence official or designee will forward the concern form to the appropriate department for review, and that the grievance official at the facility will ensure that all written grievance decisions include the date the grievance/concern was received, a summary of the resident's grievance/concern, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concern(s), a statement as to whether the grievance/concern was confirmed or not confirmed, any corrective action taken or to be taken by the facility a result of the grievance/concern, and the date the written decision was issued. Review of a grievance dated September 5, 2024, revealed that Resident R12 reported concerns regarding her breakfast meal	F 0585		

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SAUNDERS NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **190402**	**100 LANCASTER AVENUE WYNNEWOOD, PA 19096**

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F 0585 SS=E	Continued from page 19 being cold. Review of the resident's resident's grievance regarding her cold food indicated that there was no information regarding any investigation that was completed. Review of a grievance dated October 14, 2024 by Resident R15 indicated that the resident reported to the social worker (Employee E9) that on the date of her admission (October 13, 2024) her room was not clean and that someone else's belongings were in her room. The resident also reported that she asked for soup and tea and did not get it. Continued review of the grievance form regarding the allegations that her room was not clean on the date of her admission. The resident's grievance regarding her missing food items and the resident's allegations that her room was	F 0585		

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F 0585 SS=E	Continued from page 20 not cleaned when she arrived at the facilty were not addressed at all by the facility, with no evidence that an investigation was conducted, and no evidence that a solution was provided to the resident. Review of a grievance dated October 15, 2024 submitted by Resident R14's daughter regarding a number of concerns related to care and services related to medication, housekeeping, hospice services and dietary concerns that was attached to the grievance form. The daughter reported that cold food that is supposed to be hot is being delivered to her father to consume "for most meals." The daughter also reported that her father is not eating much at all and that it is even more difficult to get food in him when it is delivered cold. Continued review of the resident's daughter's concern regarding	F 0585		

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F 0585 SS=E	Continued from page 21 her father's meals indicated that "last night" was supposed to be a cheeseburger with lettuce and tomato with ketchup, crinkle fries (ketchup side), diet pudding, cranberry juice and an ensure shake. The daughter reported that the whole meal was ice cold and that there was no lettuce or tomato on the burger, no ketchup and no diet pudding. The resident's daughter reported that her mother (Resident R14's wife) went out in the hall to ask for ketchup and was told that there was none. Continued review of the grievance form indicated that there was no information on the grievance form indicating that an investigation was conducted or that any resolution was provided regarding the daughter's grievance related to cold food and missing food items. During an interview with the Nursing	F 0585		

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F 0585 SS=E	Continued from page 22 Home Administrator (NHA) and the Food Service Director on December 2, 2024, at 2:45 p.m. it was discussed that the above reference grievances provided by the facility showed no evidence that the above-refenced grievances, were addressed by the facility for Resident R12 R15 and R14. 28 Pa. Code 201.18 (b)(1)(3)(2.1)(4) Management 28 Pa. Code 201.29 (a) Resident Rights	F 0585		
F 0656 SS=D		F 0656		

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F 0656 SS=D	Continued from page 23 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	R1 care plan was updated to include the resident's sensitivities to aerosol sprays and perfumes and the effects that the use of them could have on the residents health related to the diagnosis of COPD. The DON/designee audited residents with a diagnosis of COPD to ensure appropriate care plans are in place. The facility educated licensed staff on the development of person-centered plan of care for residents with COPD that addresses sensitivities to aerosol sprays, perfumes, and the effects that the use of them could have on a resident. The DON/designee will audit new admissions with a diagnosis of COPD to ensure care plans are developed that address sensitivities to aerosol sprays and perfumes. Audits will be done weekly x 4 weeks then monthly x 2 months. Results of these audits will be submitted to the Quality Assurance Committee to determine if further action is needed.	Completion Date: **02/01/2025** Status: **APPROVED** Date: **12/23/2024**

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F 0656 SS=D	Continued from page 24 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656		

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F 0656 SS=D	Continued from page 25 Based on staff interviews, review of facility policy, and the review of clinical records, it was determined that the facility failed to ensure that a person-centered plan of care was developed for a resident related to irritants (e.g. aerosol sprays, perfumes, bleach, dust mites) and the adverse reactions that they can have on the resident's health for 1 out of 1 residents reviewed (Resident R1). Findings include: Review of the facility policy, "Care Planning Process and Care Conference," with a revision date of July 2023, indicated that each care need/problem of the resident must have a goal and interventions to address the need of the resident/patient.	F 0656		

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F 0656 SS=D	Continued from page 26 Review of the December 2024 physician orders for Resident R1 included the following diagnosis: pulmonary hypertension (increased blood pressure in the arteries of the lungs); heart failure (a condition in which the heart muscle doesn't pump blood as well as it should), chronic kidney disease (a condition in which the kidneys become damaged over time and have difficulty their essential functions), and chronic obstructive pulmonary disease (a progressive lung disease causing obstructed airflow and breathing difficulties). Review of a journal article from Ohio State University, "How fragrance affects health and effects on exposure (July 6, 2023)," indicated that short term effects of fragrances for people with lung	F 0656		

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F 0656 SS=D	Continued from page 27 disease, particularly asthma or chronic obstructive pulmonary disease (COPD), could be wheezing, shortness of breath, or other underlying symptoms. Review of a journal article from WEBMD, "Household Hazards for people with COPD (January 4, 2024)," indicated that an individual's lungs are sensitive to irritants in the air, especially if an individual has chronic obstructive pulmonary disease, and recommened staying away from cleaning products, mold, air fresheners and perfumes that could worsen symptoms of COPD. Review of information received by the State Survey Agency on November 16, 2024 included concerns regarding Resident R1 having a lung disease, and that some perfumes make her "sick". The	F 0656		

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F 0656 SS=D	Continued from page 28 concerns also described an incident that took place at the facility on or around Novmber 16, 2024 in which a nurse aide assigned to her (Employee E3) had on perfume. The report indicated that the scent of the prfume had a "suffocating effect" on Resident R1. During an interview with the Director of Nursing (DON) on December 3, 2024 at 1:11 p .m. the DON reported that she was aware of the above referenced incident, and that she spoke with the resident's nurse aide and provided her with education. Review of the education material that was reviewed with the nurse aide included educated related to "working with residents with..."varying degrees of illness and respiratory issues." The education also indicated that to maintain resident safety, "I will not wear	F 0656		

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F 0656 SS=D	Continued from page 29 strong smelling perfumes or sprays while working in in the facility, as it may aggravate residents with COPD and respiratory issues." Review of resident grievance dated April 4, 2024, indicated that the resident made a complaint about a staff member spraying aerosol air fresher which irritated her lungs. Staff education that was conducted by the facility regarding this grievance was reviewed. Review of the resident's person-centered plan of care did not include a plan of care for the resident's sensitivities to aerosol sprays and perfumes and the effects that the use of them could have on the resident's health related to the diagnosis of COPD.	F 0656		

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F 0656 SS=D	Continued from page 30 During a discussion with the DON on December 3, 2024 at 1:36 p.m. it was confirmed that there was no evidence that a person-center plan of care was developed by the facility to address the above referenced concerns related to the use of irritant (e.g. aerosol sprays and perfumes), to ensure all staff, nursing and non-nursing was aware of the impact that such could have on the resident's health. 28 Pa. Code 211.10(c) Resident care plan 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services	F 0656		

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F 0656 SS=D	Continued from page 31	F 0656		
F 0689 SS=D	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	E4 was educated by the DON on the medication administration policy. The DON/designee did an audit of the unit to ensure there were no other residents with medications left at the bedside. Licensed staff were inserviced on the Medication Administration/Disposition policy by the Facility Educator. The DON/designee will conduct random room audits of 10 rooms on each unit to ensure medications are not left at the bedside. Audits will be done weekly x 4 weeks then monthly x 2 months. Results of these audits will be submitted to the Quality Assurance Committee to determine if further action is needed.	Completion Date: **02/01/2025** Status: **APPROVED** Date: **12/23/2024**

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F 0689 SS=D	Continued from page 32 Based on observations, interviews with staff and residents, review of clinical records and facility documentation, it was determined that the facility failed to ensure adequate supervision during medication administration for 1 out of 15 residents observed (Resident R2). Fimdings include: Review of the facility policy," Medication Administration/Disposition" with a review date of June 2023, indicated that medications, both prescription and non-prescription, shall be administered under the orders of the	F 0689		

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F 0689 SS=D	Continued from page 33 attending physician, or the physician's designees. Review of Resident R2's December 2024 physician orders included diagnosisof kidney failure (a condition where the kidney reaches advanced state of loss of function); hypertension (high blood pressure); diabetes (a condition that affects an individual's blood sugar levels and can cause serious complications); cerebral infarction (a stroke); senile degeneration of the brain (a type of dementia characterized by a decline in cognitive function, memory and behavior abilities, typically occurring in older adults).	F 0689		

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F 0689 SS=D	Continued from page 34 Review of a "Decisional Capacity Evaluation," completed by the psychologist on October 16, 2024 indicted that the resident lacked the capacity to make general healthcare decisions. Review of the resident's Significant Change Minimum Data Set Assessment completed on November 13, 2024 indicated that the was assessed with moderate (average or less than average) cognitive impairment. During an observation on December 3, 2024 at 11: 20 a.m. the resident was observed in her room lying in her bed. A plastic cup with	F 0689		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0689 SS=D	Continued from page 35 approximately 4 pills inside were observed on her bedside table that was in front of her. The resident was asked who left the pills in the plastic cup, and she reported, "the nurse." The Director of Nursing (DON) was on the floor at the above referenced time, and was notified that the resident had medication in front of her that was reportedly left for her to take by "the nurse." She entered the resident's room to observe the above. During a discussion with the DON on December 3, 2024 at 11:20 a.m. it was confirmed that the medications that the resident had in her cup included the following medications: nifedipine (for hypertension); allegra	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395380	A. BLDG: __00_____ B. WING: _____	12/03/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SAUNDERS NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 190402	100 LANCASTER AVENUE WYNNEWOOD, PA 19096

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F 0689 SS=D	Continued from page 36 (for allergies); farixiga (for diabetes) and an aspirin (for cerebrovascular accident-CVA). The DON also identified the licensed nurse (Employee E4) who left the medications unattended in the plastic cup on the resident's bedside table. Review of the resident's physician orders indicated that the resident was being administered Nifedipine for hypertension; Allegra for allergic rhinitis (inflammation of the nose and sometimes the eyes and throat); Farxiga for the treatment of type 2 diabetes, and aspirin for cerebral vascular disease. Continued review of the physician orders did not include a physician's order for the resident to	F 0689		

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F 0689 SS=D	Continued from page 37 self administer medication. It was discussed with the DON on December 3, 2024 at 7:50 p.m. that review of the resident's clinical record did not show evidence that the resident was authorized to self-administer any medication on her own. 28 Pa. Code 211.12 (d) Nursing services 28 Pa. Code 211.12(d)(1) Nursing services	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SAUNDERS NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **190402**	**100 LANCASTER AVENUE WYNNEWOOD, PA 19096**

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F 0804 SS=F	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by:	F 0804	The facility cannot go back retroactively to correct this issue. Dietary staff members were educated on appropriate food temperatures. The Dietary Director/designee will conduct test tray audits on each floor weekly x 4 weeks then monthly x 2 months. Results of these audits will be submitted to the Quality Assurance Committee to determine if further action is needed.	Completion Date: **02/01/2025** Status: **APPROVED** Date: **12/23/2024**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0804 SS=F	Continued from page 39 Based on interviews with staff and residents, review of the facility tray audit form, and the completion of a lunch test tray, it was determined that the facility failed to provide food and drinks that were served at safe and appetizing temperatures on one of four nursing units (3rd floor nursing unit). Findings include: During an interview with Resident R7 on December 2, 2024, at 3:11 p.m. the resident reported that a group of residents had a meeting with the Nursing Home Administrator (NHA) a few weeks ago about "cold food" and other issues concerning the	F 0804		

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F 0804 SS=F	Continued from page 40 Dietary Department. Another resident (Resident R8) organized the meeting due to these issues being "ongoing issues" for months and not resolved by the NHA and the Dietary Director when it was discussed at various resident council meetings. Regarding the concerns with cold food, Resident R7 reported during the group meeting the NHA reported to the residents in attendance that "the burner that heats up the food was broke." During interview with Resident R4 on December 2, 2024 at 3:45 p.m. the resident reported that his food is not hot and spoke about the cold french fries that he had "the other day."	F 0804		

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F 0804 SS=F	Continued from page 41 During an interview with Resident R5 on December 3, 2024 at 11:20 a.m. Resident R5 reported that any food that she is served is cold. She reported, I would love to have hot food." Resident R5 reported that people have reported cold food at meetings, but nothing has been done about it because the food is still cold. During an interview with Resident R9 on December 3, 2024 at 12:04 p.m. Resident R9 reported that the food that she has been served is cold. Resident R9 reported that her coffee was always cold and spoke of a time when she was served cold French fries and a cold hamburger. Resident R9 also reported that a meeting was	F 0804		

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F 0804 SS=F	Continued from page 42 held "a few weeks ago "with the NHA to discuss concerns with the food and other issues related to dining that has been discussed "for months," and not resolved. The resident reported that during the meeting the group of residents were told that the device that kept the hotplates warm in the kitchen were not working. Resident R9 also reported that the food continues to be cold even after the meeting that was held "a few weeks ago," and that there was no follow up as to what was going to be done about it. During an interview with Resident R8 on December 3, 2024 at 7:00 p.m, the resident reported that she organized	F 0804		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0804 SS=F	Continued from page 43 the meeting that was held on November 14, 2024 with the NHA and other residents regarding concerns related cold food and other issues regarding their dining experience at the facility. Resident R8 reported that the concern regarding cold food had been brought up several times in various resident council meetings over the month, but reported, "we were never updated on what was being done about it, and the food continues to be cold. Cold food is not ok." Resident R8 reported that during the meeting on November 14, 2024, the NHA notified residents that the heating device that is used to keep the food warm while it is being transported to the different floors was	F 0804		

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F 0804 SS=F	Continued from page 44 broken, and it is expensive to place it. Review of resident council meeting minutes dated September 25, 2024 indicated that the 8 residents were in attendance at the meeting, with "several residents reporting that the food in the dining room was cold at times." Review of resident council meeting minutes dated October 30, 2024 indicated that 14 residents were in attendance at the meeting and "residents stated that they have arranged a separate meeting with the administrator in regard to dining services."	F 0804		

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F 0804 SS=F	Continued from page 45 Review of resident council meeting minutes dated November 27, 2024 indicated concerns with the dietary department. Resident R5 reported "the food needed to be improved." Resident R9 reported "the food is often cold" and "often run out of coffee." Resident R7 reported. "food is not hot," "can't eat cold eggs," "dinners are cold to[sic], "has to change up dishwater." Resident R6 reported, "cold food burned food." Review of a grievance dated September 5, 2024, indicated that Resident R12 reported concerns regarding her breakfast meal being cold.	F 0804		

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F 0804 SS=F	Continued from page 46 On December 2, 2024 for the lunch time meal on the third floor, test tray temperatures were taken by the dietary supervisor (Employee E7) with the facility's food thermometer, with the director of dietary present. The cart was followed up to the 3rd floor once all the trays were observed to be on the cart and it was ready to be delivered by Employee E6 (dietary aide). Employee E6 delivered the cart to the 3rd floor section of the floor that has the higher room numbers at 12:24 p.m. The first tray was observed being taken off the cart and served to a resident by the nurse aide (Employee E9) 10 minutes later at 12:34 p.m.	F 0804		

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F 0804 SS=F	Continued from page 47 The Food and Drug Administration recommends that hot foods should be kept at an internal temperature of 140 °Fahrenheit or warmer, and that cold foods should be kept at 40 degrees Fahrenheit, or colder. The tray line temperatures of the food items taken in the facility kitchen prior to them being served on the third floor were the following: the coffee was 140 degress Fahrenheit; the chicken marsala was 137 degrees; the carrots was 125 degreees; potatoes 123 degrees; pears 40 degrees, and apple juice 30 degrees. The test tray was conducted on the last tray on the 3rd floor food cart, (high end hallway) at 12:45 p.m. The	F 0804		

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F 0804 SS=F	Continued from page 48 test tray consisted of hot water, coffee, chicken marsala, carrots, potatoes, pears and apple juice. The hot water temperature was 110 degrees Fahrenheit. The coffee's temperature was 124 degrees, the chicken marsala was 106 degrees Fahrenheit. The temperature of the carrots was 101 degrees Fahrenheit, the potatoes was 113 degrees Fahrenheit. The resident's bowl of pears was 60 degrees Fahrenheit. During an interview with the Food Service Director, FSD (Employee E5) on December 2, 2024 at 12:55 p.m. it was confirmed with the FSD that the food and beverage items were not served at acceptable temperatures.	F 0804		

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F 0804 SS=F	Continued from page 49 On December 2, 2024 at 2:31 p.m. it was confirmed that the heating device that is utilized to heat the pallets that are utilized to keep the plates warm while being transported to the floors, was broken, and needs to be replaced. Continued interview with the food service director (FSD) on December 2, 2024 at 2:45 p.m. found that he noticed that the heating device was not working on November 17, 2024. The Maintenance Department was notifed to see if they could fix it, and it was found out that the heating device needed to be replaced. When the FSD was asked what interventions were put in place to ensure that meals were delivered at acceptable	F 0804		

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F 0804 SS=F	Continued from page 50 temperatures once it was known that the heating device was broken, the FSD did not provide any information during the above referenced interview. During an interview on December 2, 2024, at 4:50 p.m. the NHA confirmed that residents requested a meeting with him and that it was held on November 14, 2024 regarding resident dining concerns, which included cold food. The NHA reported knowledge of knowing that the heating device that is used to warm the pallet that helps keep the food warm while being transported to residents needed to be replaced for quite some time, but had not been	F 0804		

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F 0804 SS=F	Continued from page 51 replaced by the facility. On December 3, 2024 at 11:10 a.m. during an observation in the kitchen, the food service director confirmed that prior to the above referenced date (December 3, 2024), there were no interventions put in place to ensure that food was served to residents at acceptable temperatures. 28 Pa. Code 201.18 (b)(3) Management 28 Pa. Code 211.6 (c) Dietary Services	F 0804		

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P 5520	Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	The Provider submits the following plan of correction in good faith and to comply with federal regulations. This plan is not an admission of wrong doing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. The facility cannot go back retroactively to correct this issue. The NHA, DON, and Staffing Coordinator were educated by the Regional Nurse on the CNA staffing ratios for dayshift, evening shift and nightshift. The NHA/designee will audit staffing ratios daily as well as projected ratios for the upcoming shifts using the PA DOH staffing grid to ensure the required CNA ratios are met. Results of these audits will be submitted to the Quality Assurance Committee to determine if further action is needed.	Completion Date: **02/01/2025** Status: **APPROVED** Date: **12/23/2024**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5520	Continued from page 1 Based on a review of nursing staff schedules, it was determined that the facility failed to maintain required staffing ratios, including a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight for 6 of the 63 shifts reviewed. (10/20/24 through 12/1/2024) Findings include: Review of facility census data revealed that on October 20, 2024 , the facility census was 175 for the 7:00 a.m. through the 3:00 p.m. nursing shift which required 140.00 hours of care to residents to be	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SAUNDERS NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 190402	100 LANCASTER AVENUE WYNNEWOOD, PA 19096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 5520	Continued from page 2 provided by a nurse aide. Review of the nursing time schedules revealed only 116.4 hours of care was provided to residents by nurse aides. Review of facility census data revealed that on November 10, 2024, the facility census was 175 for the 11:00 p.m. through the 7:00 a.m. nursing shift which required 93.33 hours of care to residents to be provided by a nurse aide. Review of the nursing time schedules revealed 92.26 hours of care was provided to residents by nurse aides. Review of facility census data revealed that on November 11, 2024, the facility census was 175 for the	P 5520		

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P 5520	Continued from page 3 11:00 p.m. through the 7:00 a.m. nursing shift which required 93.33 hours of care to residents to be provided by a nurse aide. Review of the nursing time schedules revealed 90.00 hours of care was provided to residents by nurse aides. Review of facility census data revealed that on November 28, 2024, the facility census was 168 for the 11:00 p.m. through the 7:00 a.m. nursing shift which required 89.60 hours of care to residents to be provided by a nurse aide. Review of the nursing time schedules revealed only 75.93 hours of care that was provided to residents by nurse aides.	P 5520		

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P 5520	Continued from page 4 Review of facility census data revealed that on December 1, 2024 , the facility census was 171 for the 7:00 a.m. through the 3:00 p.m. nursing shift which required 136.80 hours of care to residents to be provided by a nurse aide. Review of the nursing time schedules revealed 132.00 hours of care that was provided to residents by nurse aides. Review of facility census data revealed that on December 1, 2024, the facility census was 171 for the 11:00 a.m. through the 7:00 a.m. nursing shift which required 91.20 hours of care to residents to be provided by a nurse aide. Review of the nursing time schedules revealed	P 5520		

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P 5520	Continued from page 5 75.02 hours of care was provided to residents by nurse aides. During a discussion with the Nursing Home Administrator and the Director of Nursing on December 3, 2024 at 7:50 p.m. it was discusse review of the three weeks of staffing indicated date(s) in which the nurse aide ratios did not meet the state requirements.	P 5520		
P 5530		P 5530		

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P 5530	Continued from page 6 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	The Provider submits the following plan of correction in good faith and to comply with federal regulations. This plan is not an admission of wrong doing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. The facility cannot go back retro actively to correct this issue. The NHA, DON, and staffing coordinator were educated by the regional nurse on the LPN staffing ratios on the nightshift. The NHA/designee will audit staffing ratios daily as well as projected ratios for the upcoming shifts using the PA DOH staffing grid to ensure the required LPN ratios are met. Results of these audits will be submitted to the Quality Assurance Committee to determine if further action is needed.	Completion Date: **02/01/2025** Status: **APPROVED** Date: **12/23/2024**

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P 5530	Continued from page 7 Based on review of nursing staff schedules and interviews with staff, it was determined that the facility failed to maintain required staffing ratios, including one Licensed Practical Nurse (LPN) per 40 residents during the overnight shift, on 1 of the 63 shifts reviewed. (10/20/24) Review of facility census data revealed that on October 20, 2024, the facility census was 176, for the 11:00 p.m. through the 7:00 a.m. nursing shift, which required 35.20 hours of care to residents to be provided by a LPN. Review of the nursing time schedules, revealed that only 33.74 hours of care that was provided to residents by LPN's	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 8 During a discussion with the Nursing Home Administrator and the Director of Nursing on December 3, 2024 at 7:50 p.m. it was review the three weeks of staffing indicated date(s) in which the LPN ratios did not meet the state requirement.	P 5530		
P 5640		P 5640		

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P 5640	Continued from page 9 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	The Provider submits the following plan of correction in good faith and to comply with federal regulations. This plan is not an admission of wrongdoing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. The facility cannot go back retroactively to correct this issue. The NHA, DON, and Staffing Coordinator were educated by the Regional Nurse on the state required direct resident care hours of 3.2 per patient day (PPD). The NHA/designee will audit the daily PPD as well as the projected PPD for the upcoming day using the PA DOH gird to ensure the required PPD is being met. Results of these audits will be submitted to the quality assurance committee to determine if further action is needed.	Completion Date: **02/01/2025** Status: **APPROVED** Date: **12/23/2024**

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P 5640	Continued from page 10 Based on review of facility staffing documentation, it was determined failed to provide a minimum of 3.2 hours of direct care for each resident in a 24-hour period for 13 days out of 21 days of scheduling reviewed. (October 14, 2024 through December 1, 2024) Findings include: Review of facility nursing staffing sheets for the weeks of October 14, 2024 through October 20, 2024, November 8, 20204 through 14, 2024, and November 25, 2024 through December 1, 2024 revealed the following days where the staffing hours of direct resident care fell	P 5640		

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P 5640	Continued from page 11 below the required 3.20 hours: October 15 2024, there was only 3.17 hours of direct care provided to residents. October 17, 2024, there was only 3.18 hours of direct care provided to residents. October 18, 2024, there was only 3.15 hours of direct care provided to residents. October 20, 2024, there was only 2.94 hours of direct care provided to residents. On November 8, 2024 there was	P 5640		

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P 5640	Continued from page 12 only 3.08 hours of direct care provided to residents. On November 10, 2024, there was only 3.15 hours of direct care provided to residents. On November 11, 2024, there was only 3.14 hours of direct care provided to residents. On November 12, 2024, there was only 3.15 hours of direct care provided to residents. On November 13, 2024, there was only 3.11 hours o direct care provided to residents.	P 5640		

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P 5640	Continued from page 13 On November 14, 2024, there was only 3.16 hours o direct care provided to residents. On November 29, 2024, there was only 3.16 hours of direct care provided to residents. On November 30, 2024, there was only 3.16 hours of direct care provided to residents. On December 1, 2024, there was only 3.0 hours of direct care provided to residents. During a discussion with the Nursing Home Administrator and the Director of Nursing on December 3, 2024 at	P 5640		

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P 5640	Continued from page 14 7:50 p.m. it was reviewed the three weeks of staffing indicated dates in which hours of direct care for each resident did not meet the state requirement of 3.20.	P 5640		

Certified End Page

SAUNDERS NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 190402

SURVEY EXIT DATE: 12/03/2024

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY