STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: 00 B. WING:	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE.** **WYNDMOOR, PA 19038**

(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 a Medicare/Medicaid Recertification Survey, Civil Rights Compliance Survey and State Licensure Survey completed on January 10, 2024, it was determined that Wyndmoor Hills Rehabilitation and Nursing Center, was not in compliance with the 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		
F 0584 SS=D		F 0584		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: 00 B. WING:	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE.** **WYNDMOOR, PA 19038**

(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 0584 SS=D	Continued from page 1 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	1. Rooms 201, 204, 207, 213, 214, 220, 228, 301, and 334 were given a key to their locked drawer. Resident R63 was given a key to his drawer. Resident R58 received his $200.00. 2. Audit of all residents was done to see if anybody wants a key. Anybody who requests one will receive one. 3. Staff will be educated on the components of this regulation with an emphasis on maintaining a safe, clean, comfortable, and homelike environment. 4. Audits will be done on all new admissions to ensure they are being offered a key 1x week for 1 month , 2x a month for one month and then 1x a month for 1 month 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/06/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0584 SS=D	Continued from page 2 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0584 SS=D	Continued from page 3 Based on reviews of clinical records, observations of resident rooms, interviews with residents and staff, review of policies and procedures and review of the admission agreement, it was determined that the facility failed to exercise reasonable care for the protection of resident's property from loss or theft for two of four residents reviewed. (Residents R58 and R63) Findings include: A review of the facility's policy titled release of resident's personal belongings dated 2017 revealed that the facility was responsible for protecting the personal belongings of each resident. A review of the facility's admission agreement containing the established resident rights revealed that the facility was responsible for making reasonable accommodations and efforts to safeguard Resident's personal property. The agreement indicated that the facility was responsible to assist each resident in securing personal	F 0584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: 00 B. WING:	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE.** **WYNDMOOR, PA 19038**

(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 0584 SS=D	Continued from page 4 belongings, valuables or cash. The admission agreement indicated that this was a resident right to have his or her personal belongings protected while living at the facility. Interview with the Nursing Home Administrator, Employee E1, at 1:00 p.m., on January 9, 2025 confirmed that the facility had a cabinets in each resident's room. The administrator also confirmed that there were no residents who had or offered keys for the cabinets to safekeeping there personal belongings. The administrator reported that a total of nine residents who resided in rooms 201, 204, 207, 213, 214, 220, 228, 301 and 334 wanted a lock and key cabinet system to safe guard their belongings. Clinical record review for resident R58 revealed a comprehensive assessment MDS (an assessment of care needs) dated October 4, 2024 that indicated that this resident was alert and oriented. This assessment also indicated that this resident had no impairments or functional limitations of abilities using	F 0584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0584 SS=D	Continued from page 5 the upper extremities. Resident R58 was interviewed at 10:00 a.m., on January 8, 2025 and reported that he had been missing money ($200.00 dollars) since August, 2024. Resident R58 also reported that he had not been offered the opportunity to safe guard his cash. Observations of Resident R58 and his room revealed that there was a cabinet that had a lock installed; however there was no system or key available for the resident to secure his possessions. Clinical record review for Resident R63 revealed a comprehensive assessment MDS (an assessment of care needs) dated December 19, 2024 that indicated that this resident was alert and oriented. The assessment also indicated that this resident had no impairment of his upper extremities. Interview with Resident R63 at 10:30 a.m., on January 8, 2025 revealed that this resident was admitted to the facility on September 12, 2024.	F 0584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0584 SS=D	Continued from page 6 Observations of Resident R63's bedroom revealed that the resident had a cabinet with a lock installed; however the resident had no system or key to lock the cabinet. 28 Pa. Code 205.72 Furniture 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(2)(3) Management	F 0584		
F 0609 SS=D		F 0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0609 SS=D	Continued from page 7 483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0609	1. Grievance/concern dated November 6, 2024, regarding Resident R1 was reported. 2. Last 4 months of grievances will be audited to ensure any grievance that need to be reported, was reported. 3. Staff will be educated on the components of this regulation with an emphasis on timely and accurate reporting of alleged violations. 4. Audits will be done to ensure all grievances that need to be reported have been reported 1x week for 1 month , 2x a month for one month and then 1x a month for 1 month 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/06/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: 00 B. WING:	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE.** **WYNDMOOR, PA 19038**

(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 0609 SS=D	Continued from page 8 Based on interviews with resident and staff and review of clinical records, review of facility documentation and review of facility policy, it was determined that the facility failed to report an allegation of suspected abuse and neglect to the Survey Agency for one of 17 residents reviewed. (Resident R1). Findings include: Review of Resident R1's admissions Minimum Data Set (MDS-an assessment of resident's needs) dated November 14, 2024 indicated that the resident was alert and oriented and able to make needs known. Continue review of the MDS revealed that the resident had diagnoses of chronic obstructive pulmonary disease, neuromuscular dysfunction of bladder, multiple sclerosis, malignant neoplasm of the large intestine, was frequently incontinent of bowel and bladder and required a staff member to assist with transfers. Review of Resident R1's clinical record revealed	F 0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0609 SS=D	Continued from page 9 that Resident R1 was alert and oriented and diagnosed with colon cancer. The resident had loose stools and periods of incontinence of bowels and gastro intestinal upset. Review of Resident R1's care plan revealed that the resident was care planned at risk for falls and needing assistance of one staff with transfers. Review of a grievance/concern form dated November 6, 2024 revealed that at approximately 9:00 to 10:00 PM the resident started having uncontrollable bowl movements. The resident said he called nursing to come but they did not arrive. The resident then attempted to use the bathroom by himself and fell to the floor. The resident indicated BM was all over him, the toilet, and the floor. When the nursing assistant (NA) Employee E30 finally came to clean him, he stated she had an attitude and talked disrespectfully to him. The resident stated this occurred numerous times throughout the shift. Resident stated one instance where the NA came to help him, but the supervisor	F 0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER	**8601 STENTON AVE. WYNDMOOR, PA 19038**
STATE LICENSE NUMBER: **21610201**	

(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 0609 SS=D	Continued from page 10 (Registered Nurse (RN) Employee E29 told the NA not to help him and said "She did not have to help him." The resident said the nurse and NA said that he stunk, and complained he made a big mess. Resident R1 stated the nurse told the resident to "Shut up." The resident said he started to argue back. Resident R1 said by the end of the shift the resident was fed up and only combated the disrespect and aggression given to him and also apologized for having as many BM's as he had and explained it was from his cancer, and he cannot feel he has to go until it is too late. The resident also told the surveyor the two staff members spoke to each other in a different language in front of the resident that could have been African. It was confirmed on January 10, 2025, at 1:00 p.m. the above incident with allegations of abuse and neglect were not reported as required. 28 Pa. Code 211.12(d)(5) Nursing service	F 0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER	**8601 STENTON AVE. WYNDMOOR, PA 19038**
STATE LICENSE NUMBER: **21610201**	

(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 0609 SS=D	Continued from page 11	F 0609		
F 0610 SS=E		F 0610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0610 SS=E	Continued from page 12 483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0610	1. A PB-22 was completed for Resident R120. Resident R58 was given $200. The reportable incident regarding Resident R22 on August 13, 2024, will be properly investigated. 2. Grievances for last 4 months will be audited to ensure proper investigations were done. 3. Staff will be educated on the components of this regulation with an emphasis on properly investigating, preventing, and correcting alleged violations. 4. Grievance's will be audited to ensure proper investigations 1x week for 1 month , 2x a month for one month and then 1x a month for 1 month 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/06/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0610 SS=E	Continued from page 13 Based on review of facility documents, facility policies and procedures, clinical records reviewed, and staff interview, it was determined that the facility failed to conduct complete and thorough investigations of allegations of physical abuse, neglect and misappropriation of property for 4 of 17 residents reviewed (Resident R1, R 120, R22, R58). Findings include: Review of facility policy " Abuse Prevention Program" dated November 30, 2024 , indicated "protect our residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representative, friends, visitors, or any other individuals". Under bulletin # 7. it further states " Investigate and report any allegations of possible abuse within timeframes as required by the federal and state requirement." A review of the policy titled abuse investigation and	F 0610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0610 SS=E	Continued from page 14 reporting dated November 30, 2024 also revealed that the purpose of the policy was to ensure that all residents were free from abuse, neglect, misappropriation of resident property and exploitation. The policy said that the facility was responsible for development and implementing policies and procedures to prevent abuse, neglect, misappropriation of property or mistreatment of residents. The policy indicated that the nursing home administrator had overall responsibility for the implementation of the abuse prevention program policies and procedures. The policy indicated that the nursing home administrator was responsible for the investigation of any allegation of resident abuse. The facility was responsible for the protection of the residents from the alleged perpetrator during the investigation. The policies indicated that the administrator was to supply supporting documents related to the alleged violation of abuse. The administrator was responsible for conducting a complete investigation and conclusion of the investigation; which was to be reported to the resident and the resident's responsible party. Upon	F 0610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: 00 B. WING:	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE.** **WYNDMOOR, PA 19038**

(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 0610 SS=E	Continued from page 15 conclusion of the investigation, the nursing home administrator was responsible for implementing abuse prevention measurers. The nursing home administrator was also responsible for submitting a written document and report of findings to the Department within five working days of the occurrence of the incident. Review of Resident R120's clinical record revealed that the resident was admitted to the facility on October 25, 2024. Review of Resident 120's Minimum Data Set (MDS - a periodic assessment of care needs) dated October 31, 2024, revealed a Brief Interview for Mental Status (BIMS) of 15 which indicated that the resident was cognitively intact. Review of the faciltiy documentation reported to the State Survey Agency on October 31, 2024, revealed "[Resident R120] reported that the nurse attempted to administer a medication that she was unfamiliar	F 0610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0610 SS=E	Continued from page 16 with after refusing it, the nurse placed her finger in her mouth trying to open her mouth to take the medication and she pushed the nurse away. She described the nurse as an African or Jamaican with an accent". The facility reported that an alleged perpetrator was not identified. A review of the facility's full investigation revealed that an alleged perpetrator, Licensed Nurse Employee E6, was identified as being assigned to the 3-11 shift on October 31, 2024. In her written statement dated October 31, 2024, Employee E6 stated: I worked on 10/31/2024 3-11 I did not put my hand or finger in resident's mouth. I will ever do such thing. I'm an African American I do not have braids. I do not have an accent.". During an interview on January 10, 2025, at 9:20 a.m. Director of Nursing, Employee E2 and Administrator, Employee E2 confirmed that the facility failed to conduct a thorough investigation of an allegation of abuse by not notifying the Department of the alleged perpetrator.	F 0610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: 00 B. WING:	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE.** **WYNDMOOR, PA 19038**

(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 0610 SS=E	Continued from page 17 Clinical record review for Resident R58 revealed a comprehensive assessment MDS dated October 4, 2024 that indicated this resident was cognitively intact. The assessment also indicated that this resident had full functional abilities of the upper and lower extremities. Resident R58 was interviewed at 10:00 a.m., on January 8, 2025 and reported that he had been missing money ($200.00 dollars) since August, 2024. Resident R58 also reported that he had not been offered the opportunity to safe guard his cash in a locked drawer or place his money in an accounting service at the facility. On August 8, 2024 the Department received a report of possible misappropriation of property for Resident R58. The report indicated that Resident R58 reported that he was missing money, $200.00 dollars. The report indicated that the administrator confirmed with the resident and his wife that the amount of money in Resident R58's possession was	F 0610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0610 SS=E	Continued from page 18 $200.00 dollars. The report indicated that the resident, his wife and the administrator identified an alleged perpetrator, a nursing assistant, Employee E28. There was no documentation of a complete and thorough report into this allegation of misappropriation of property for Resident R58 that was available for review. Interview with the Nursing Home Administrator, Employee E1, at 11:00 a.m., on Janaury 9, 2025 confirmed that the facility had failed in completing a thorough investigation into the allegation of misappropriation of property for Resident R58 on August 8, 2024. The Nursing Home Administrator said that the investigation was not concluded, since we have not been able to reach the resident's wife by telephone. Interview with Resident R58, during the survey revealed that this resident wanted to have the missing money ($200.00) reimbursed to him, by the facility.	F 0610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0610 SS=E	Continued from page 19 Clinical record review for Resident R22 revealed a quarterly MDS assessment dated December 20, 2024 that indicated this resident was cognitively intact. The assessment also indicated that the resident had functional impairment on one side of her lower extremity (right foot amputation). The assessment said that Resident R22 required assistance of staff for toileting (getting on and off the toilet and chair to bed/bed to chair transfers). Clinical record review for Resident R22 revealed a physical therapy evaluation for January 8, 2025 that indicated the resident was receiving active physical therapy for standing and walking. The physical therapist documented on Janaury 8, 2025 that this resident performed walking with the wheeled walker about six feet with minimum care giver assistance. The therapist documented that the resident was using a diabetic shoe on the right foot. On August 13, 2024 the State Survey Agency received a report of alleged physical abuse for Resident R22. The report indicated that on August	F 0610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0610 SS=E	Continued from page 20 13, 2024 the daughter of Resident R22 reported to the facility that her mother told her that a nurse aide, Employee E 27, had yanked her by the collar; while she was standing. There was no documentation of a complete and thorough report into this allegation of physical abuse for Resident R22 that was available for review. Interview with the Nursing Home Administrator, Employee E1 and Director of Nursing, Employee E2 at 12:45 a.m., on Janaury 9, 2025 revealed that the Nursing Home Administrator failed to interview and document a statement from Resident R22 about the circumstances surrounding the rough treatment that occurred on August 13, 2024. Further during interview it was confirmed that there was no statement documented from Resident R22's family member, who reported the possible physical abuse. In addition, the Nursing Home Administrator and Director of Nursing failed to interview and document statements from other alert and oriented residents that received care from the perpetrator,	F 0610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: 00 B. WING:	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE.** **WYNDMOOR, PA 19038**

(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 0610 SS=E	Continued from page 21 nursing assistant, Employee E27, during the month of August, 2024. Review of Resident R1's admissions Minimum Data Set dated November 14, 2024 indicated the resident was alert and oriented able to make needs known. The resident was diagnosed with chronic obstructive pulmonary disease (disease process that causes decreased ability of the lungs to perform), neuromuscular dysfunction of bladder, multiple sclerosis slow progressive disease of the central nervous system), malignant neoplasm of the large intestine. The resident was assessed as frequently incontinent of bowel and bladder and required a staff member to assist with transfers. Continued review of Resident R1's clinical record revealed that the resident was alert and oriented. The resident was diagnosed with colon cancer and had loose stools and periods of incontinence of bowels and gastro intestinal upset. Review of the resident's current care plan revealed	F 0610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0610 SS=E	Continued from page 22 that Resident R1 was care planned a fall risk needing assistance of one staff with transfers. Review of a grievance/concern form dated November 6, 2024 revealed that at approximately 9:00 to 10:00 p.m. the resident started having uncontrollable bowl movements. The resident said he called nursing to come but they did not arrive. The resident then attempted to use the bathroom by himself and fell to the floor. The resident indicated BM was all over him, the toilet, and the floor. When the nursing assistant (NA) Employee E30 finally came to clean him, he stated she had an attitude and talked disrespectfully to him. The resident stated this occurred numerous times throughout the shift. Resident stated one instance where the NA came to help him, but the supervisor (Registered Nurse (RN) Employee E29 told the NA not to help him and said "She did not have to help him." The resident said the nurse and NA said that he stunk, and complained he made a big mess. Resident R1 stated the nurse told the resident to "Shut up." The resident said he started to argue	F 0610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0610 SS=E	Continued from page 23 back. Resident R1 said by the end of the shift the resident was fed up and only combated the disrespect and aggression given to him and also apologized for having as many BM's as he had and explained it was from his cancer, and he cannot feel he has to go until it is too late. The resident also told the surveyor the two staff members spoke to each other in a different language in front of the resident that could have been African. It was confirmed on January 10, 2025, at 1:00 p.m. the above incident was not investigated as required. 28 Pa Code: 201.18 (e)(1)(2) Management 28 Pa Code: 201.29 (a)(c) Resident Rights 28 Pa Code: 211.12 (c)(d)(1)(3)(5) Nursing services.	F 0610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: 00 B. WING:	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE.** **WYNDMOOR, PA 19038**

(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 0656 SS=D	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 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	F 0656	1. Resident R220's care plan has been updated. 2. 5 residents care plans will be audited to ensure proper comprehensive plan. 3. Staff will be educated on the components of this regulation with an emphasis on developing and implementing comprehensive care plans. 4. 5 care plans will be audited to ensure proper comprehensive care plan 1x week for 1 month , 2x a month for one month and then 1x a month for 1 month 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/06/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0656 SS=D	Continued from page 25 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0656 SS=D	Continued from page 26 Based on review of clinical records, review of facility policy, and interviews with staff, it was determined that the facility failed to develop and implement a comprehensive care plan related to Resident R220's diagnosis of post-traumatic stress disorder for one of 17 resident records reviewed (Resident R220). Findings include: Review of the facility's policy titled, "Trauma-Informed Care" not date, stated the purpose of the policy is to establish guidelines for implementing trauma-informed care (TIC) in the long-term care facility to support residents who may have experienced trauma. The goal is to provide care that is safe, respectful, and responsive to the effects of trauma while fostering a supportive environment. Care will be provided in a manner that prevents re-traumatization and promotes healing and empowerment. The policy defines TIC as an approach that recognizes the prevalence of trauma and understands its impact and integrate knowledge	F 0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0656 SS=D	Continued from page 27 of trauma into care policies to ensure the physical and emotional safety of the resident. Review of Resident R220's psychiatric evaluation dated, January 1, 2025, revealed the resident was diagnosed with depression (major loss of interest in pleasurable activities), anxiety, and Post Traumatic Stress Disorder (PTSD- a mental condition that's caused by an extremely stressful or terifying event) The therapy note indicated the resident was alert and oriented, calm, logical with good insight and judgment. The note further stated that the resident's traumatic past was also discussed. The resident was stated on Seroquel (an antipsychotic medication used for various mental health conditions) two years ago because of this trauma. The note further recommended staff to monitor the resident for increased anxiety. During an interview on January 7, 2024, at approximately 11:30 a.m. Resident R220 said the resident was stuck on the elevator on Friday (January 3, 2025). The resident explained the fear	F 0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: 00 B. WING:	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE.** **WYNDMOOR, PA 19038**

(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 0656 SS=D	Continued from page 28 and feeling of being stuck in that elevator triggered the resident's PTSD and the tragic stories of his past resurfaced. Further review of Resident R220 clinical record revealed no evidence the facility developed a plan of care for the resident's PTSD that included the resident's trauma related that related to the resident's needs preferences and triggers. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.10 (d)(1) Nursing services	F 0656		
F 0677 SS=D		F 0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0677 SS=D	Continued from page 29 483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 0677	1. The hairdresser came to the facility on 1-30-25. 2. Residents will be audited for grooming. 3. Staff will be educated on the components of this regulation with an emphasis on providing appropriate ADL care for dependent residents. 4. 5 residents will be audited to ensure proper grooming 1x week for 1 month , 2x a month for one month and then 1x a month for 1 month 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/06/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0677 SS=D	Continued from page 30 Based on reviews of policies and procedures, interviews with residents and staff and review of the outside services agreement, it was determined that facility failed to offer each resident who was not able to carry out activities of daily living for grooming, the opportunity for hair dresser or barber services to meet their needs. (Residents R24, R63, R22,R58, R64, R5, R19, R35, R23, R1, R65, R51 and R62). Findings include: A review of the undated facility policy titled beauty and barber services revealed that the purpose of the policy was to provide each resident with access to professional grooming services in a safe, hygienic and respectful manner while enhancing their quality of life. The policy indicated that professional beauty and barber services were to be available and offered to the residents on a regular basis. The services offered would be haircuts, styling, coloring, shaving and other grooming based on the residents'needs.	F 0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0677 SS=D	Continued from page 31 A review of the service agreement dated September, 2024, revealed that an agreement was established for the facility with a cosmotology and barber service to visit the facility on a regular basis to provide the grooming care needs of each resident. Interview with the nursing home administrator, Employee E1, at 10:45 a.m., on January 10, 2025 confirmed that the facility had not been accomodating any of the residents' needs for grooming. There had been no visits to the facility, by the hair dresser or barber services, since September, 2024 the initiaion of the outside resources. The Residents (R24, R63, R22,R58, R64, R5, R19, R35, R23, R1, R65, R51 and R62) that were interviewed throughout the days of the survey reported that they thought they had to perform their own grooming; because the facility did not inform them of the availability of the cosmotologist or	F 0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0677 SS=D	Continued from page 32 barber services within the building. 28 PA. Code 211.10(a)(b)(c)(d) Resident care policies 28 PA. Code 201.21(c)(e) Use of outside resources	F 0677		
F 0685 SS=D		F 0685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: 00 B. WING:	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE.** **WYNDMOOR, PA 19038**

(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 0685 SS=D	Continued from page 33 483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by:	F 0685	1. Resident R55's eye exam was scheduled. 2. Residents will be audited to ensure they all had a eye exam within the proper time. 3. Staff will be educated on the components of this regulation with an emphasis on ensuring residents receive necessary treatment and devices to maintain hearing and vision. 4. 5 Residents will be audited to ensure they had a eye exam in the proper time 1x week for 1 month , 2x a month for one month and then 1x a month for 1 month. 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/06/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0685 SS=D	Continued from page 34 Based on clinical record review, resident and staff interviews, it was determined the facility failed to ensure each resident receives proper treatment and assistive devices to maintain vision abilities for one of 17 resident records reviewed (Resident 55). Findings include: Review of Resident R55's clinical record revealed the resident was admitted on November 15, 2023, with diagnoses of muscle weakness, lack of coordination, abnormal gait and mobility, high blood pressure, and glaucoma (a chronic eye disease that causes damage to the optic nerve). Interview with Resident R55 on January 7, 2025, at 10:30 a.m. indicated the resident had not seen the eye doctor since admission. This was confirmed by the Director of Nursing on January 10, 2025, at 3:00 p.m. there was no evidence Resident R55 had an eye exam since the resident's admission to the facility.	F 0685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: 00 B. WING:	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE.** **WYNDMOOR, PA 19038**

(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 0685 SS=D	Continued from page 35 28 Pa. Code 211.12 (d) (5) Nursing services	F 0685		
F 0688 SS=D	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 0688	1. Resident R23 had a side rail installed. 2. Full house side rail assessment has been done. 3. Staff will be educated on the components of this regulation with an emphasis on increasing or preventing the decrease in residents' range of motion and mobility. 4. 5 residents will be audited to ensure they have a side rail if needed 1x week for 1 month , 2x a month for one month and then 1x a month for 1 month 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/06/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0688 SS=D	Continued from page 36 Based on observations, interviews with resident and staff, review of clinical records and facility policy, it was determined that the facility failed to provide assistant device for one of 17 residents reviewed to maintain independence with bed mobility (Resident R23). Findings include: Review of the facility's policy for bed safety (undated) states the resident should be assessed for safety, medical conditions comfort and freedom of movement as well as input from the resident. If side rails are used there should be a resident assessment and consultation with physician and input from the resident. Side rails may be used if assessment and consultation with the physician has determined that they are needed to help manage a condition or to help the resident reposition or move in bed and transfer. Review of Resident R23's the quarterly MDS (an assessment of resident needs) date November 6,	F 0688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0688 SS=D	Continued from page 37 2024, indicated the resident was alert and oriented, able to make decisions for self, independent with all activities of daily living, and continent of bowel and bladder. Interview with Resident R23 on January 8, 2025, at 9:30 a.m. revealed that the facility told the resident that he/she would be getting bed rails since admission to the facility last May. The resident further stated "I have to wait for the maintenance department to put them on my bed. I go to the bathroom so often it would be nice to have a little help getting up in the middle of the night." Review of Resident R23's physician orders revealed ¼ side rails when in bed as enabler for bed mobility dated May 21, 2024. Surveyor inquired Resident R23's bed rail assessment and questioned why it was not in use. Regional Registered Nurse Employee E13 on January 10, 2025, at 5:00 p.m. stated that the facility does not use them and the assessment	F 0688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0688 SS=D	Continued from page 38 indicated the resident was assessed as not needing the side rails. Review of the side rail evaluation dated May 21, 2024, revealed the assessment inaccurately answered "N/A" for not assessed for question pertaining to the resident's potential for bed rail use. 28 Pa. Code 211.12 (d)(1)(3) Nursing services	F 0688		
F 0689 SS=E		F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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=E	Continued from page 39 483.25(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	1. An Ad Hoc QAPI meeting was immediately conducted to update the smoking policy and its enforcement. The new smoking policy allows for more smoking times for residents deemed safe to improve residents compliance and enforcement of the policy. Residents were educated that any violation of the smoking policy will result in immediate action with potential for 30 day discharge notice to be given. R24 was educated on the new smoking policy and was informed that he will not be able to keep cigarettes on his person. R5 was reassessed and it was determined that he should be on oxygen PRN. He was educated that he may not go outside to smoke with a oxygen tank on him. R63 was reeducation on the new smoking policy. 2. A Full house audit on all residents identified as smokers was done to ensure they are aware of the policy and that there no others identified smokers.	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/13/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER	**8601 STENTON AVE. WYNDMOOR, PA 19038**
STATE LICENSE NUMBER: **21610201**	

(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=E	Continued from page 40	F 0689	3.Staff will be educated on the components of this regulation with an emphasis on accident prevention, supervision, and appropriate use of devices. 4. 5 residents who smoke will be audited to ensure they understand the smoking policy and are being properly supervised 1x a week for 1month , 2x a month for 1 month and 1x a month for 1 month. 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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=E	Continued from page 41 Based on clinical record reviews, observations, reviews of the facility policies and procedurs and interviews with staff, it was determined that for three of four residents reviewed, the facility failed to provide adequate supervision for residents who smoke. (Resident R24, R5 and R63) Findings include: The facility policy entitled " Smoking policy " revised December 2016 stated "Smoking is not allowed inside the facility under any circumstances". According to the facility's established smoking policies and procedures, any residents found violating the smoking agreement would have their smoking priviledges revoked. The smoking agreement also indicated that the resident was also recommended to the physician for immediate discharge from the facility. On January 8, 2024, at 10:30 a.m. a resident council group meeting was held with six alert and oriented residents	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: 00 B. WING:	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE.** **WYNDMOOR, PA 19038**

(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=E	Continued from page 42 (Residents R14, R60, R47, R20, R17, R11) revealed that there was a resident who was a smoker and smokes in his room. The residents stated that the facility has not taken action to prevent him from doing so. All resident confirmed that there are oxygen concentrators near, and they are afraid of a potential fire in the building. A review of the clinical record indicated that Resident R24 was admitted to the facility on November 1, 2023, with a diagnosis of tobacco use. It further revealed that the last Smoking Assessment was conducted on November 29, 2024, which revealed that Resident R24 continues to smoke cigarettes and is safe to smoke. Further review of the clinical progress notes revealed on February 21, 2024 "[Resident R24] was caught outside smoking at times which not the schedule smoking times. Resident R24 has been repeatedly re-educated about the smoking policy. He does not follow. Resident R24 has been caught several times sharing cigarette, storing cigarettes in	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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=E	Continued from page 43 his room and smoking during non-smoking hours." A progress notes dated February 27, 2024, revealed " SW (Social Worker), Administrator and Ombudsman and Activity Director conducted a mandatory meeting with the facility smokers. [Resident R24] was in attendance. The smokers were re-educated on the facility smoking policy and the consequences of being non-compliant. All attendees were told a 30-day discharge could be issued to any residents, if caught [Resident R24] agreed to the meeting". A clinical progress note written by activity staff, dated March 8, 2024, regarding "[Resident R24] was seen outside smoking during nonsmoking hours, [Resident R24] has been none-compliant with the facility policy, the resident has been educated of the hazards of smoking and the safety of others." Review of nursing notes date on August 9, 2024, revealed "Nurse aide stated smell of cigarette smoking coming from resident room during morning	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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=E	Continued from page 44 rounds. No actual smoking observed but strong smell. Educated provided to resident. Nursing supervisor made aware". On January 9, 2025, at 2:50 p.m., an interview with the Social Worker, Employee E13, revealed that there were other instances before New Year where a smoking odor was allegedly detected in Resident R24's room. However, Employee E13 stated that the Administrator advised not to document these instances, explaining that a record of non-compliance would make it more difficult to find a placement for Resident R24 in other facilities. On January 10, 2025, at 8:45 p.m., an interview with the Director of Nursing confirmed that a morning meeting was held on January 3, 2025, during which the team discussed concerns regarding Resident R24 smoking. However, it was noted that no documentation of this meeting or the discussion was recorded. The Director of Nursing also acknowledged that there were additional incidents involving Resident R24.	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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=E	Continued from page 45 On January 10, 2024, at 9:59 a.m., an interview was conducted with Housekeeping Aide, Employee E7. She reported that on January 2, 2025, she noticed a strong smell of cigarettes in Resident R24's room. She also observed three cigarette burn holes on Resident R24's lunch tray, along with a burnt-out cigarette and ashes on the tray table. Employee E7 stated that she immediately reported the incident to her supervisor, Employee E11, who subsequently notified the entire administrative team, including the Activity Director, Social Worker Director, Administrator, and Director of Nursing. A review of the clinical record for Resident R24 did not indicate any clinical documentation of this incident. A review of grievances from October 2024-January 2024 did not indicate any documentation of Resident R24 smoking in his room. On January 10, 2024, at approximately 10 a.m., an interview was conducted with the Administrator,	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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=E	Continued from page 46 Employee E1, who confirmed that a discussion took place on January 3, 2025, regarding Resident R24. The Administrator attempted to speak with Resident R24, but the resident was not present in his room at the time. The conversation occurred later, on Monday, January 6, 2025, during which two lighters and a pack of empty cigarettes were confiscated from Resident R24. The Administrator acknowledged that the confiscation should have occurred on January 2, 2024, when the facility first became aware of Resident R24 smoking in his room. The Administrator also agreed that the facility failed to enforce its policy by not issuing a 30-day notice to Resident R24 for continued noncompliance, as required on March 8, 2024. Observations at 9:00 a.m., on January 7, 2025 revealed that Resident R5 was outside the building in the designated smoking area with a cylinder attached to the back of his wheel chair that was full of oxygen. Resident R5 was seated next to Resident R63 who was smoking.	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: 00 B. WING:	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE.** **WYNDMOOR, PA 19038**

(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=E	Continued from page 47 The director of nursing confirmed that the oxygen cylinder attached to Resident R5's wheel chair was turned off. The director of nursing, Employee E2, also confirmed that it was the facility policy to ensure that there was no chance that the combustable oxygen and flame from the cigarette would ignite into fire, by prohibiting any oxygen cylinders to be in or near the designated smoking area. The director of nursing also reported that the oxygen cylinder was supposed to be detached from the resident's wheel chair before he left the second floor nursing unit for the designated smoking area. A review of the facility's smoking policy and procedures indicated that the designated smoking times were 10:15 a.m. and 3:15 p.m. and that the area was to be supervised by staff during these times. Further review of the smoking policy revealed that oxygen cylinders were prohibited in the designated smoking area.	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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=E	Continued from page 48 Resident R5 was in violation of the smoking policy having an full oxygen cylinder tank attached to his wheel chair. Interview with Resident R5 revealed that this resident was a smoker and smoking regularly at the facility. Both Resident R5 and R63 were also in violation of the smoking policy; because they were outside in the desinated smoking area not at the deignated smoking times without staff supervision. Clinical record review for Resident R5 revealed an admission date to the facility of September 13, 2024. Clinical record review revealed a comprehensive admission assessment (MDS-an assessment of care needs) dated September 20, 2024 that indicated that this resident had a diagnosis of chronic obstructive pulmonary disease (disease process that causes decreased ability of the lungs to perform) . This assessment also indicated that this resident was cognitively intact. Clinical record review for Resident R63 revealed a quarterly assessment (mds-an assessment of care	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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=E	Continued from page 49 needs) dated December 19, 2024 that indicated this resident was cognitively intact. Interview with Resident R63 at 2:15 p.m., on January 8, 2025 revealed that the resident did not realize that he was violating the facility's smoking policy times of 10:15 a.m., and 3:15p.m., daily, since no one ever explained a smoking policy or agreement with him. Resident R63 was admitted to the facility on September 12, 2024 and reported that he was smoking on a routine basis since admission. There was no documentation to indicate that the facility reviewed the smoking policy or had a smoking agreement signed by Resident R63, that was available for review. The lack of notification of Resident R63 about the seriousness of smoking outside the designated smoking times without supervision was confirmed during an interview with the nursing home administrator, Employee E1 at 10:30 a.m., on January 7, 2025. The administrator also confirmed the lack of documentation to indicate that the staff at the facility reviewed the smoking policy and agreement with Resident R63.	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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=E	Continued from page 50 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0689		
F 0690 SS=D		F 0690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0690 SS=D	Continued from page 51 483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 0690	1. Resident R64 was assessed for the removal of the catheter. 2. Residents who have catheter will be assessed for removal of the catheter. 3. Staff will be educated on the components of this regulation with an emphasis on proper assessment and management of bowel/bladder incontinence, catheters, and UTIs. 4. Residents with a catheter will be audited for a removal of catheter 1x week for 1 month , 2x a month for one month and then 1x a month for 1 month 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/06/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER	**8601 STENTON AVE. WYNDMOOR, PA 19038**
STATE LICENSE NUMBER: **21610201**	

(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 0690 SS=D	Continued from page 52 This REQUIREMENT is not met as evidenced by:	F 0690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0690 SS=D	Continued from page 53 Based on resident clinical records reviewed, interview with staff and review of facility policy, it was determined that the facility did not ensure one resident that entered the facility with an indwelling catheter was assessed for removal of the catheter or the resident's clinical condition demonstrates that catheterization was necessary for one of 17 resident records reviewed (Resident R64). Findings include: Review of the facility's policy Urinary Continence and Incontinence Assessment and Management not dated indicates an indwelling urinary catheter will be used "Sparingly for appropriate indications only." As part of the initial and ongoing assessments, the nursing staff and physician will screen for information related to urinary continence. Examples of sources of such information may include the resident, family, or a hospital discharge describing placement of an indwelling urinary catheter during a recent hospitalization. When a resident is admitted from the	F 0690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0690 SS=D	Continued from page 54 hospital with a newly placed indwelling catheter, they physician will evaluate the potential for removing it, depending on the current conditions and the rationale for the original placement. The policy continues to state the physician will identify situations in which an indwelling urethral or suprapubic catheter are indicated and will document why alternatives are not feasible. Indwelling catheters shall not be used as a substitute for nursing care of the resident with urinary incontinence Review Resident R64's clinical record revealed the resident was admitted to the facility with an indwelling urinary catheter on November 12, 2024, after an acute hospitalization for an infection status post spinal surgery, diagnosis of sepsis, and developed multiple pressure injuries that included an unstageable pressure ulcer on the resident's sacrum and left and right lateral malleolus (ankle). Review of Resident R64's care plan revealed a foley catheter care plan was developed with goals that included remaining free from catheter related	F 0690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: 00 B. WING:	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE.** **WYNDMOOR, PA 19038**

(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 0690 SS=D	Continued from page 55 trauma, and to monitor and document for pain and discomfort. On January 7, 2025 at 12:00 p.m. the Director of Nursing clarified the reason Resident R46's had a foley catheter is that the resident was admitted with a wound and was incontinent of urine. The foley would have kept the wound dry. Review of the initial wound care note dated November 13, 2024, revealed the specialist's recommendations for wound care included a Pressure reduction mattress, Offload heels, Wheelchair pressure reduction cushions, Repositioning and Nutritional consult. The physician noted the importance of proper wound care and adequate nutritional intake and wound preventions measures, Further review of the Resident R64's clinical record did not reveal the rationale for placement, or a diagnosis of its need nor supported clinical documentation that the indwelling catheter was	F 0690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: 00 B. WING:	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE.** **WYNDMOOR, PA 19038**

(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 0690 SS=D	Continued from page 56 needed. Documentation received from the Regional Registered Nurse Employee E13 on January 10, 2025, at 5:00p.m, stated the resident continued to have the foley catheter to promote (sacral) wound healing with a previous history of sepsis but was unable to show documented evidence that justified Resident R64'a need for a foley. In addition a wound vac was ordered for the resident that covered the pressure area with a sponge and protected the surround skin with a drape that would further promote wound healing. 28 Pa. Code 211.12 (D)(1)(3) Nursing services	F 0690		
F 0694 SS=D		F 0694		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0694 SS=D	Continued from page 57 483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0694	1. Resident R220 was assessed to ensure there were no adverse effects from this alleged behavior. Adequate treatment and care for the intravenous catheter (IV) line were provided in accordance with professional standards of practice. 2.Residents with a catheter will be assessed to ensure they had no adverse effects 3. Staff will be educated on the components of this regulation with an emphasis on the proper administration and monitoring of parenteral/IV fluids. 4. Residence with a catheter will be audited to ensure they had no adverse effects 1x week for 1 month , 2x a month for one month and then 1x a month for 1 month 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/06/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0694 SS=D	Continued from page 58 Based on observations, reviews of clinical records, and interviews with resident and staff, it was determined that the facility failed to provide adequate treatment and care for intravenous catheter (IV) line in accordance with professional standards of practice for one of 17 resident records reviewed (Resident R220). Findings included According to the standard of nursing practice guidelines the Pharmacy and Therapeutic peer-reviewed journal for managed care and hospital formulary management February 2011, titled Capping Intravenous Tubing and Disinfecting Intravenous Ports Reduce Ricks of Infection. The article states, "Failure to place a sterile cap on the end of a reusable intravenous(IV) administration set that has been removed from a primary administration set saline lock, or IV catheter hub, with the tubing left hanging between uses is exposed to potential contaminants that can lead to infection if the non-sterile IV set is reconnected to the patient's	F 0694		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0694 SS=D	Continued from page 59 IV access. Health care practitioners who administer medications are well versed in the use of aseptic technique during the medication-use process and that they are familiar with the conditions under which sterile techniques must be applied. These conditions should include (1) covering the exposed end of IV tubing used for intermittent infusions with a sterile cap between uses and (2) dis infecting the port before connecting tubing or a syringe to the port. Review of Resident R220 physician admission notes, dated December 31, 2024, indicated Resident R220 was diagnosed with Type II Diabetes (a chronic condition where the body does not use insulin effectively or does not produce enough insulin), high blood pressure, neuropathy, and a nonhealing diabetic foot ulcer diagnosed with osteomyelitis(bone infection) that required IV (intravenous) antibiotics of vancomycin (used to treat serious infections). Interview and observation of Resident R229 on January 10, 2025, at approximately 10:00 a.m.	F 0694		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0694 SS=D	Continued from page 60 stated that at the hospital they would use the "orange caps" on the end of the resident's IV line and at the facility does not use them. Review of Resident R220's hospital records revealed the PICC Single Lumen was placed on dated December 24, 2024. Following insertion of PICC line the dressing was documented as clean dry and intact and the line status "capped." The Interview with Unit Manager Register Nurse Employee E15 on January 10, 2024, at 10:00 a.m. with Resident R220 confirmed the IV line should be capped when not in use. 28 PA Code 211.12(d)(5) Nursing services	F 0694		
F 0695 SS=D		F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0695 SS=D	Continued from page 61 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	1. Residents R2 and R5 were provided with respiratory care and supplemental oxygen as ordered by the physician. 2. Residents on oxygen will be audited to ensure they are following MD orders. 3. Staff will be educated on the components of this regulation with an emphasis on providing appropriate respiratory and tracheostomy care. 4. 3 residents on oxygen will be audited to ensure they are following MD orders 1x week for 1 month , 2x a month for one month and then 1x a month for 1 month. 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/06/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0695 SS=D	Continued from page 62 Based on a review of clinical records and facility policies and procedures, observations of care and services, and interviews with staff, it was determined that the facility failed to consistently provide respiratory care and supplemental oxygen as ordered by the physician for two of 28 residents reviewed. (Resident R2 and R5). Findings included: A review of the facility policy titled "Oxygen Administration" dated October, 2010, stated "The purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Review the resident's care plan to assess for any special needs of the resident". A review of Resident 2's clinical record revealed the resident was admitted on October 29, 2021, with diagnoses to include: chronic respiratory failure with hypoxia (not enough oxygen passes from the lungs	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0695 SS=D	Continued from page 63 to the blood, making it difficult to breath), and congestive heart failure (a chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen). A physician order dated May 20, 2024, specified oxygen at 3 liters/min via nasal cannula continuously. During an initial facility tour on January 7, 2025, at 11:19 a.m., oxygen level was observed to be 1.5 liter on the Resident's R2 oxygen concentrator. On January 7, 2025, at 11:34 a.m., an interview with the licensed nurse, Employee E4, confirmed that the incorrect liter of oxygen was being administered to Resident R2. Clinical record review for Resident R5 revealed a comprehensive admission assessment (MDS-an assessment of care needs) dated September 13, 2024. The assessment indicated that this resident had a diagnosis of chronic obstructive pulmonary disease. The assessment also indicated that	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0695 SS=D	Continued from page 64 Resident R5 required special treatment with oxygen therapy. Clinical record review for Resident R5 revealed a physician's order dated September 16, 2024 for oxygen to be administered to Resident R5 at 2 liters/min via a nasal cannula continuously for shortness of breath. Observations of resident R5 at 9:00 a.m., on January 7, 2025 revealed that the resident was not receiving the oxygen in accordance with the physician's orders. This observation was confirmed by the Director of Nursing, Employee E2 who visualized the valve of the oxygen tank and reported that the valve connected to the oxygen tank was not turned on. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12 (d)(1)(5) Nursing services	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0695 SS=D	Continued from page 65	F 0695		
F 0743 SS=D	483.40(b)(2) No Behavior Difficulties Unless Unavoidable §483.40(b)(2) A resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty or a documented history of trauma and/or post- traumatic stress disorder does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that development of such a pattern was unavoidable; This REQUIREMENT is not met as evidenced by:	F 0743	1. Resident R220 was seen by psychological services. 2. Residents with PTSD will be seen by psychological services to ensure proper plan is in place. 3. Staff will be educated on the components of this regulation with an emphasis on managing behavioral difficulties appropriately. 4. Audits of 5 residents with PTSD will ensure they have been seen by psychiatric services 1x week for 1 month , 2x a month for one month and then 1x a month for 1 month. 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/06/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0743 SS=D	Continued from page 66 Based on review of clinical record, and interviews with resident and staff, it was determined that the facility failed developed a plan of care for a resident with a diagnosis of PTSD and provided psychological services after the resident was stuck inside the facility's elevator for one of 17 residents reviewed. (Resident R220) Findings include: Review of Resident R220's nursing note dated December 31, 2024 revealed that the resident was admitted to the facility with a past medical history of hypertension (elevated blood pressure), depression (major loss of interest in pleasurable activities), anxiety and Post Traumatic Stress Disorder (is a mental health condition that's caused by an extremely stressful or terrifying event - either being part of it or witnessing it. Symptoms may include flashbacks, nightmares, severe anxiety and uncontrollable thoughts about the event). The	F 0743		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0743 SS=D	Continued from page 67 resident was alert and oriented x 3 (person, place and time) with adequate vision. Review of Resident R220's physician admission notes, dated December 31, 2024, indicated Resident R220 was also diagnosed with a nonhealing diabetic foot ulcer with osteomyelitis (bone infection) requiring intravenous antibiotic. Review of the initial psychiatric evaluation note dated, January 1, 2025, revealed the resident was alert and oriented, calm, logical with good insight and judgment. The resident talked about his traumatic past and stated the he needed something to help him sleep better. The resident stated to the psychiatrist that he was started on the antipsychotic medication Seroquel about 2 years ago to help with sleep because of his trauma. During an interview on January 7, 2024, at approximately 11:30 a.m. Resident R220 said the resident was stuck on the elevator on Friday (January 3, 2025). The resident described when the	F 0743		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0743 SS=D	Continued from page 68 resident was on the elevator it felt like it was trying to stop and was very bumpy and making loud noises. When it did stop the resident indicated the elevator was not aligned with the floor and the doors wouldn't open. Resident R220 described the situation as terrifying and it felt like "death." The resident said that fear triggered the resident's PTSD causing the resident to re-visit the physical and emotional sensations of these damaging experiences. The resident could not say how long the elevator was stuck but described it as it felt like forever. The resident stated, "I soiled myself because I was so upset. I thought I smelled smoke but there wasn't a fire. When they finally got me off the elevator, it took a long time to calm down. When the resident went outside to try to calm down the resident stated the Nursing Home Administrator (NHA) approached the resident with the Maintenance Director, Employee E4 and the Social Worker, Employee E3. The NHA said to me, 'Yes, they told me about the elevator yesterday.' Resident R220 said "That's when I stopped and couldn't hear no more. He knew that elevator was broken yesterday	F 0743		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: 00 B. WING:	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE.** **WYNDMOOR, PA 19038**

(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 0743 SS=D	Continued from page 69 and never shut it down." Just when I thought I was calming down I got upset again. I am still upset, and I have been requesting to speak with therapy. The incident triggered the PTSD and brought back a lot of feelings. I am afraid the elevators are not safe. I was using the steps but that put too much stress on my bad foot and had no choice but to use the elevators again. Interview with the Activity Director, Employee E14 on January 8, 2025, at approximately 2:00 p.m. indicated even after Resident R220 got off of the elevator, she could still hear him screaming for at least 30 minutes. "Everyone heard him screaming. Everyone knew he got stuck." Interview with Social Services, Employee E3 on January 8, 2025, at approximately 3:00 p.m. said it was upsetting to see the resident so distraught. There was nothing I could do or say to calm him down, so for the longest time, I cuddled Resident R220, a grown man in my arms like a baby."	F 0743		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0743 SS=D	Continued from page 70 Interview with the NHA on January 8, 2025, at 12:00 p.m. confirmed Resident R220 was very upset after the incident and spoke to him afterwards while the resident stood outside of the facility. He also confirmed the elevator was shut down "After" the Resident R220 incident. The NHA stated he was aware of a sound coming from the elevator during an interview on January 10, 2025, at 3:00 p.m. The NHA stated, without supporting evidence, a call was made to the elevator company late December because of a sound he was hearing from the elevator. The NHA alleges that during that phone call the elevator company diagnosed the sound using the NHA description and said it was nothing. Review of Resident R220's clinical record revealed no documented evidence that the physician and/or therapist was made aware of the incident nor the resident's request to be seen by therapy. Continued review of the resident's clinical record	F 0743		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0743 SS=D	Continued from page 71 revealed no evidence the facility developed a plan of care to address the resident's diagnosis of anxiety, depression, and PTSD and to address the incident getting stuck in the elevator. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services	F 0743		
F 0791 SS=D		F 0791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0791 SS=D	Continued from page 72 483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;	F 0791	1. Resident R55 has been scheduled to see the dentist. 2. Residents will be audited to ensure they have been seen by the dentist in the proper time. 3. Staff will be educated on the components of this regulation with an emphasis on providing access to routine and emergency dental services. 4. 5 residents will be audited to ensure they have been seen by the dentist in the proper time 1x week for 1 month , 2x a month for one month and then 1x a month for 1 month 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/06/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0791 SS=D	Continued from page 73 §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by:	F 0791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0791 SS=D	Continued from page 74 Based on a review of clinical records and interview with resident and staff, it was determined that the facility did not ensure that routine dental services were provided to residents in a timely manner for one of 17 records reviewed (Resident R55) Findings include: Review of Resident R55 clinical record revealed the resident was admitted on November 15, 2023, diagnosed with muscle weakness, lack of coordination abnormal gait and mobility, high blood pressure, and glaucoma (a chronic eye disease that causes damage to the optic nerve). Interview with Resident R55 on January 7, 2025, at 10:30 a.m. indicated the resident had not seen the dentist since admission. It was confirmed by the Director of Nursing on January 10, 2025, at 3:00 p.m. there was no evidence Resident R55 had a dental exam since	F 0791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0791 SS=D	Continued from page 75 admission. 28 Pa. Code 211.12 (d) (5) Nursing services	F 0791		
F 0812 SS=D		F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: 00 B. WING:	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE.** **WYNDMOOR, PA 19038**

(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 0812 SS=D	Continued from page 76 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	1. All kitchen areas, dishroom, ceiling tiles, metal shelving, walk-in refrigerator units, and light fixtures were immediately cleaned. The low-temperature dish machine was scheduled for maintenance. The tubing that dispenses the chemical sanitizer was fixed. Any items on the dry food storage closet floor were removed. 2. Other areas of the kitchen not mentioned in the 2567 were audit for cleanliness as well. 3. Staff will be educated on the components of this regulation with an emphasis on proper food procurement, storage, preparation, and serving in a sanitary manner. 4. Kitchen will be audited to ensure it is properly clean and storage is put away properly 1x week for 1 month , 2x a month for one month and then 1x a month for 1 month 5. The findings of these quality monitoring's to be reported to the	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/06/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0812 SS=D	Continued from page 77	F 0812	Quality Assurance/Performance Improvement Committee monthly x6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: 00 B. WING:	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE.** **WYNDMOOR, PA 19038**

(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 0812 SS=D	Continued from page 78 Based on observations of the food and nutrition services department, reviews of County Office of Public Health report, interviews with staff and policies and procedure reviews, it was determined that the dietary services was not being operated under sanitary conditions. Findings include: A review of the undated policy titled cleaning and sanitizing of dietary areas and equipment revealed that all kitchen areas and equipment was to be maintained in a sanitary manner free of build up of food debris, grease and soil. A review of the undated policy titled floors revealed the floors must be cleaned daily. Floors must be cleaned of obvious litter, food spillagestacky substances and excessive water. The ceiling tiles in the hot food preparation area	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0812 SS=D	Continued from page 79 contained a coating of grease and dried splattered food. The ceiling tiles were brown stained and water damaged evidening leaking of water above the ceiling tiles. The ceiling light fixtures in the hot food preparation area contained dirt and dead bugs. The low temperature dish machine, when tested was not registering the proper concentration of chemical sanitizer to effectively sanitize the dishes, utencils, cups, bowls meal trays. This confirmed with the director of dietary, Employee E17 at 10:50 a.m., on January7, 2025. The director of dietary reported that the tubing that dispenses the chemical sanitizer into the dish machine to acheive effective sanitation and cleaning of the dishes, utencils, cups, bowls meal trays was leaking and had to be replaced. The dishroom flooring along the perimeter of this room was heavily soiled with a build up of food debris, dirt and mice droppings. The metal shelving inside the walk-in refrigerator units was was heavily soiled with dirt, food spillage	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: 00 B. WING:	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE.** **WYNDMOOR, PA 19038**

(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 0812 SS=D	Continued from page 80 and sticky substances. The dry food storage closet inside the main kitchen contained boxes of canned and dried foods that were being stored stacked on top of each other and directly on the floor. This closet was not easily cleanable and provided a place for pests to burrow, live and breed. A review of the food service inspection report from the County Public Health Department dated December 19, 2024 revealed that insects and rodents were cited as out of compliance, rodent droppings were observed throughout the main kitchen, food contact services were not cleaned and sanitized, the chlorine sanitizer concentration of the dish machine was observed less than 50ppm, a non-protected opening to the loading dock was noted with the door leading outside that was not sealing properly upon closing, floor tiles were missing, pooling of water was cited in hot food preparation and dish room area.	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0812 SS=D	Continued from page 81 28 PA. Code 201.18(b)(1)(3)(e)(1)(2.1) Management 28 PA. Code 201.149(a) Responsibility of licensee 28 PA. Code 205.13(b) Floors	F 0812		
F 0842 SS=D		F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0842 SS=D	Continued from page 82 483.20(f)(5), 483.70(h)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 0842	1. The administrator responsible no longer works for the facility as of September 2024. Staff were educated on the importance of proper documentation. 2. Audit of the current residnts for the last 30 days will be done to ensure proper documentation any concerns will be corrected immeditley 3. Staff will be educated on the components of this regulation with an emphasis on maintaining resident records with identifiable information securely and accurately. 4. 5 reisndts notes were audit for proper documentation 1x week for 1 month , 2x a month for one month and then 1x a month for 1 month. 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/06/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0842 SS=D	Continued from page 83 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER	**8601 STENTON AVE. WYNDMOOR, PA 19038**
STATE LICENSE NUMBER: **21610201**	

(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 0842 SS=D	Continued from page 84 This REQUIREMENT is not met as evidenced by:	F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0842 SS=D	Continued from page 85 Based on review of clinical records, as well as resident and staff interviews, it was determined that the facility failed to maintain clinical records that were complete and accurately documented for 1 of 17 residents reviewed (Resident R24) . Findings include: On January 9, 2025, at 2:50 p.m., an interview with the Social Worker, Employee E13, revealed that there were other instances before New Year where a smoking odor was allegedly detected in Resident R24's room. However, Employee E13 stated that the Administrator advised not to document these instances, explaining that a record of non-compliance would make it more difficult to find a placement for Resident R24 in other facilities. On January 10, 2024, at 9:59 a.m., an interview was conducted with Housekeeping Aide, Employee E7. She reported that on January 2, 2025, she noticed a strong smell of cigarettes in Resident R24's room. She also observed three cigarette burn	F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0842 SS=D	Continued from page 86 holes on Resident R24's lunch tray, along with a burnt-out cigarette on the tray table. Employee E7 stated that she immediately reported the incident to her supervisor, Employee E11, who subsequently notified the entire administrative team, including the Activity Director, Social Worker Director, Administrator, and Director of Nursing. A review of the clinical record for Resident R24 did not indicate any clinical documentation of this incident. A review of grievances from October 2024-January 2024 did not indicate any documentation of Resident R24 smoking in his room. On January 10, 2025, at 8:45 p.m., an interview with the Director of Nursing confirmed that a morning meeting was held on January 3, 2025, during which the team discussed concerns regarding Resident R24 smoking. However, it was noted that no documentation of this meeting or the discussion was recorded. The Director of Nursing also acknowledged that there were additional incidents	F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0842 SS=D	Continued from page 87 involving Resident R24. 28 Pa. Code 211.5(f) Clinical Records 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0842		
F 0908 SS=F		F 0908		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0908 SS=F	Continued from page 88 483.90(d)(2) Essential Equipment, Safe Operating Condition §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by:	F 0908	1. The elevator parts arrived and the elevator was fixed on 1/8/25. The kitchen heat has been restored and the doors were immediately fixed. 2. All kitchen doors will be audited to make sure they are working functionally. 3. Staff will be educated on the components of this regulation with an emphasis on maintaining essential equipment in a safe operating condition. 4. Elevators and the kitchen heat will be audited to sure they are working correctly 1x week for 1 month , 2x a month for one month and then 1x a month for 1 month. 5. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/06/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0908 SS=F	Continued from page 89 Based on observation, interviews with resident and staff, review of resident's clinical records, facility documentation and policy reviewed, it was determined that the facility failed to ensure essential mechanical equipment was in safe operating condition for one of two elevators and the heating system in the main kitchen. Findings include: Review of Resident R220 physician admission notes, dated December 31, 2024, indicated Resident R220 was diagnosed with Type II Diabetes (a chronic condition where the body does not use insulin effectively or does not produce enough insulin), high blood pressure, neuropathy, and a nonhealing diabetic foot ulcer diagnosed with osteomyelitis(bone infection) that required I.V. antibiotics of vancomycin (used to treat serious infections). On January 7, 2024, at 11:30 a.m. Resident R220	F 0908		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0908 SS=F	Continued from page 90 said he was stuck on the elevator Friday (January 3, 2025), on the way down from the third floor by himself. The resident described the elevator making very loud thumping sounds, describing as if the elevator wanted to stop while it made its way down. When the elevator finally stopped to his floor it wasn't aligned properly with the floor so the doors wouldn't open. Resident R220 described the incident as "Terrifying" and said it felt like "Death." The resident said that he didn't expect being in a small, enclosed elevator would trigger the resident's PTSD. The resident said he was outside trying to calm down when the Nursing Home Administrator (NHA) approached at the same time the Maintenance Director Employee E4 and the Social Worker E3 standing with them. The NHA said to the resident, 'Yes, they told me about the elevator yesterday.' Resident R220 said "That's when I stopped and couldn't hear anymore. He knew that elevator was broken yesterday and never shut it down.". Documentation received from the facility revealed	F 0908		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0908 SS=F	Continued from page 91 the elevator company was aware of those sounds and sensations felt on the elevator when they recommended servicing the elevator to correct these concerns on December 13, 2024. These "Sounds and Sensation" were not addressed only until after Resident R220 incident. Observations of the main kitchen at 10:45 a.m., on January 7, 2025 revealed that there was no functioning heating system inside the food and nutrition department. The food and nutrition services department was where foods and fluids were being prepared, stored and delivered to the nursing units for the residents as nutritional consumption daily. Testing of the air temperature, in the presence of the director of dietary services, Employee E17 and the maintenance staff, Employee E4 revealed that the ambient temperatures inside this kitchen was between 46 and 56 degrees Fahrenheit. Observations of the doorway located near the director of dietary's office and hot food prepararion	F 0908		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0908 SS=F	Continued from page 92 area inside the main kitchen revealed that the doors were not closing or sealing completely. Cold air was billowing through the gaps left after the doors were firmly closed. Dietary staff (Employees E21, E20, E19, E18) were observed wearing coats, hats and extra clothing in an effort to keep themselves warm. Dietary staff said that there was no heat inside the kitchen since November, 2024. Dietary staff reported that it was extremly difficult to perform their assigned duties in the main kitchen; since the working conditions were undesirable. Interview with the Director of Dietary Services revealed that on Janaury 7, 2025 there were four dietary staff members (Employees E22, E23, E24 and E25) home sick. The dietary staff reported to the director of dietary services that they thought the unfavorable working conditions in the main kitchen were causing their illnesses. Interview with the Nursing Home Administrator at	F 0908		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0908 SS=F	Continued from page 93 2:15 p.m., on January 7, 2025 confirmed that the essential equipment (heating system) inside the main kitchen had been out of service, since November, 2024. The administrator explained that five air handling units needed to be installed, a heat pump, condensers, a transformer and ductwork to ensure that there was heat and a comfortable air temperature level for dietary staff to preform their daily tasks of preparing foods, fluids, cleaning and sanitizing dishes, equipment and the environment inside the main kitchen. 28 PA. Code 201.18(b)(1)(3)(e)(1)(2.1) Management 28 PA. Code 205.61(a) Heating requirements for existing construction	F 0908		
F 0921 SS=F		F 0921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0921 SS=F	Continued from page 94 483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:	F 0921	1. Resident R49 was immediately cleaned. The sanitizer dispenser near the resident's bedroom door was fixed. Multiple room repairs were made. 2. Hand sanitizers and rooms will be audited to ensure they are with in compliance. 3. Staff will be educated on the components of this regulation with an emphasis on maintaining a safe and sanitary environment. 4. 5 Hand sanitizers and 5 rooms will be audited to ensure they are with in compliance 1x week for 1 month , 2x a month for one month and then 1x a month for 1 month. 5. The findings of these quality monitoring's to be reported to QAPI monthly x6 months.	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/06/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0921 SS=F	Continued from page 95 Based on observations, review of facility documentation, and resident and staff interviews, it was determined that the facility failed to ensure that a safe, functional, and comfortable environment was maintained for two of ten residents rooms observed and laundry room . (Resident R49 and Resident R10) Findings: On January 7, 2025, at 10:43 a.m., an observation of Resident R49's bathroom revealed a dirty toilet with a brown substance and a soiled brief placed next to the toilet. Additionally, a sanitizer dispenser located near the resident's bedroom door was observed to be broken. On January 7, 2025, at 10:49 a.m., an observation of Resident R19's room revealed a broken baseboard near the table and a missing drawer on the left side of her desk. This observation was confirmed by Licensed Nurse, Employee E4	F 0921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0921 SS=F	Continued from page 96 Observation conducted on January 7, 2025, at 10:58 a.m. revealed Resident R10's baseboard was off the wall next to her restroom wall in the corner. On January 7, 2025, at 11:58 a.m., an interview with the Maintenance Director, Employee E4, confirmed the previously noted observations and revealed that the closet door in Room 310 was also broken. On January 9, 2025, at 1:05 p.m., a laundry tour was conducted with the Housekeeping Director, Employee E11. During the tour, Employee E11 confirmed the presence of a large hole in the floor near the industrial washing machine, which provides an open access point for pests. 28 Pa. Code 202.28(b)(3) Management	F 0921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER	**8601 STENTON AVE. WYNDMOOR, PA 19038**
STATE LICENSE NUMBER: **21610201**	

(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 0925 SS=F	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by:	F 0925	1. Gaps on the doors and holes in the dietary director's office were fixed. 2. Our pest control will do a house audit on our pest control to ensure compliance. 3. Staff will be educated on effective pest control measures. 4. Pest logs will be audited 1x week for 1 month , 2x a month for one month and then 1x a month for 1 month. 5. The findings will be reported to QAPI x6 months.	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/06/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: 00 B. WING:	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE.** **WYNDMOOR, PA 19038**

(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 0925 SS=F	Continued from page 98 Based on observations, resident and staff interviews and review of the pest control logs, pest control company management program and review of facility policies, it was determined that the facility failed to maintain an effective pest control program to ensure that the facility was pest free for two of two nursing units, the food and nutrition services department and laundry room. (2nd Floor nursing unit, 3rd Floor nursing unit, main kitchen and laundry room) Findings include: A review of the undated facility policy titled pest control revealed that pest control was extremely important to ensure safe foodservice. The policy indicated that pest control was important to prevent spread of disease. The pest control policy indicated that mice and roaches carry a wide range of diseases such as salmonella and staphylococcus. The policy and procedures to prevent household pest from entering the building were to fill all voids, store foods in tight containers, dispose of garbage	F 0925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0925 SS=F	Continued from page 99 and trash proptly and in sealed containers, clean and sanitize the kitchen environment routinely. On January 7, 2025, at 11:52 a.m., an interview was conducted with Resident R35, who reported observing two mice in her room the previous day. She stated that she had notified the Assistant Administrator, Employee E8. A review of the 3rd-floor maintenance log revealed that this incident was not recorded in the logbook. Upon inspection of Resident R35's closet, mice droppings were observed, a finding confirmed by the Maintenance Director, Employee E4. On January 8, 2025, at approximately 10:30 a.m. during the resident council group meeting on the second-floor dining room there was observation of flies. On January 9, 2025, at 1:05 p.m., a laundry tour was conducted with the Housekeeping Director, Employee E11. During the tour, Employee E11 confirmed the presence of a large hole in the floor	F 0925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0925 SS=F	Continued from page 100 near the industrial washing machine, which provides an open access point for pests. On January 9, 2025, at approximately 1:30 p.m. on the third floor at the nursing station there was observation of fruit flies. License Nurse, Employee E5 confirmed the observations. On January 9, 2025, at 1:40 p.m., an interview was conducted with the receptionist, Employee E12, who confirmed observing fruit flies in the reception area. She stated that when she notices pests, she documents the findings on a sticky note rather than recording them in the pest logbook. She also reported that the pest control vendor removes the sticky notes during their visits. Employee E12 acknowledged that she had not received training on logging pest observations into the logbook. On January 9, 2025, at 1:46 p.m. an interview was held with License Nurse, Employee E9 who reported that when residents do tell her about seeing pest "then I go into their room to validate it and then	F 0925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0925 SS=F	Continued from page 101 notify my supervisor". This employee does not log pest observations into the Pest Logbook. On January 9, 2025, at 1:51 p.m. an interview was held with Nurse aide, Employee E10 who reported that she/he was not aware of the pest control log book and has not been documenting pest observations. Interview with Resident R1 on January 9, 2025 at 12:19 p.m. said there is one thing I can't stand is mice and I see them in my room. Interview with Resident R23 on January 9, 2025 at 2:30 p.m. said she sees mice all the time and held candy that was half eaten with mice teeth marks on the candy. A review of the pest logbook on the 3rd floor for the past two months the revealed: On 12/5/2024 mouse and flies 3rd floor On 12/15/2024 mouse 3rd floor room 202	F 0925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0925 SS=F	Continued from page 102 On 12/29/2024 mouse 3rd floor 202, 238 On 1/2/2025 bugs room 328 On 1/5/2025 bugs room 328 Observations of the food and nutrition department at 10:45 a.m., on January 7, 2025 revealed pest droppings (mice) along side and underneath the hot food prepartion equipment (convection ovens, stove) inside the main kitchen. Mice tracks and rubbings were evident along the wall area behind the hot foo preparation equipment. Observations of the metal doors that opened directly outside the building revealed that the doors were not sealing upon closure. A four inch gap was noted underneath the doors at the threhold of the doors and another four inch gap was noted between the doors. These voids were allowing easy access to the building for pests and rodents. Observations of the director of dietary 's office located inside the main kitchen of the food and nutrition department revealed holes in the walls and	F 0925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0925 SS=F	Continued from page 103 pest droppings (mice). Observations of the janitor supply area/alcove inside the main kitchen revealed pest droppings (mice) were evident on the floor along the cove molding along with rub marks and tracks from the mice. A review of the pest control operators reports for October, November, December, 2024 and January 2025 revealed that the main kitchen, storage areas and dish room of the food and nutrition department were continuously being treated for common household pests (roaches and mice). The pest control operator's reports repeated the same issues over the months of October, November, December, 2024 and January, 2025 as follows: The pest control operator mention that the main kitchen needs to be thoroughly cleaned. Old dried food debris and drink spillage was noted throughout the main kitchen; which was food for pests to live and breed.	F 0925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396115	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WYNDMOOR HILLS REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **21610201**	**8601 STENTON AVE. WYNDMOOR, PA 19038**

(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 0925 SS=F	Continued from page 104 The pest control operator pointed out voids that need filling and patching throughout the main kitchen so that pests have no place to hibernate. The pest control operator advised the dietary staff to timely dispose of left over foods on trays in the dishroom; to prevent rodent and pest feeding. The pest control operator pointed out that water was not to be left in sinks; providing food for common household pests. 28 PA. Code 201.14(a) Responsibility of licensee 28 PA. Code 201.18(b)(1)(3)(e)(1)(2.1) Management	F 0925		

Certified End Page

WYNDMOOR HILLS REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 21610201

SURVEY EXIT DATE: 01/10/2025

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