

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2026
NAME OF PROVIDER OR SUPPLIER  Wyomissing Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 East Wyomissing Blvd Reading, PA 19611	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, facility documentation review, and staff interview, it was determined that the facility failed to file timely reports of allegations of abuse to officials, including the State Survey Agency, for two of six sampled residents. (Residents 3 and 5) Findings include: Review of the facility policy titled, Abuse Policy - Prevention and Management, last reviewed August 2025, revealed that the facility prohibited abuse, mistreatment, neglect, and exploitation, for all residents. Procedures to prohibit abuse included the reporting of incidents, investigations, and the facility's response to the results of their investigations immediately upon receiving information concerning a report of suspected neglect or abuse. The designee was to report allegations involving abuse or neglect to the appropriate state and local authorities. Incidents resulting in no serious bodily injury were to be reported no later than 24 hours after identifying a suspicion of abuse. Clinical record review revealed that Resident 3 had diagnoses that included intellectual disability, liver transplant failure, heart failure, and type II diabetes. The Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident had no memory impairment. Review of facility documentation dated December 29, 2025, revealed that the resident was heard yelling from his room that Resident 4 had struck him. Resident 3 was observed being shoved onto his bed before the residents were separated. There was a lack of evidence to support that the facility reported the incident of alleged abuse to the required state and local agencies until January 19, 2026, 21 days after the incident. Clinical record review revealed that Resident 5 had diagnoses that included dementia with agitation and type II diabetes. The MDS assessment dated [DATE], indicated that the resident had significant memory impairment. Review of facility documentation dated January 14, 2026, revealed that Resident 5 was observed in an altercation in which his roommate, Resident 6, shoved him onto his bed. Resident 5 had injuries to his lip and eye. There was a lack of evidence to support that the facility reported the incident of alleged abuse to the required state and local agencies until January 19, 2026, five days after the incident. In an interview on January 19, 2026, at 1:20 p.m., the Administrator confirmed that the facility failed to report the incidents of alleged abuse to the required state and local agencies in a timely manner. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 201.29(a) Resident rights.</p>

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

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