STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395237	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wyomissing Health and Rehabilitation Center	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined that the facility failed to implement physician's orders for two of five sampled residents. (Residents 1 and 4)Findings include: Clinical record review revealed that Resident 1 had diagnoses that included Parkinson's disease, aphasia (inability to speak), and history of a stroke (a medical condition involving the interruption of blood flow to a part of the brain resulting in brain damage). A review of Resident 1's Minimum Data Set assessment dated [DATE], revealed the resident had an abdominal feeding tube through which he received nutrition and medications. A physician's order dated December 27, 2025, directed staff to administer a medication (amlodipine besylate) daily for hypertension. Review of Resident 1's January 2026 medication administration records (MAR) revealed there was no documented evidence that staff administered this medication at 2:00 p.m., as scheduled, on January 2, 2026. A physician's order dated December 26, 2025, directed staff to administer a medication (carbidopa-levodopa) three times per day for Parkinson's disease. Review of Resident 1's January 2026 MAR revealed there was no documented evidence that staff administered this medication at 12:00 p.m., as scheduled, on January 2, 2026. A physician's order dated December 26, 2025, directed staff to administer a medication for muscle spasms (baclofen) three times per day. Review of Resident 1's January 2026 MAR revealed there was no documented evidence that staff administered this medication at 12:00 p.m., as scheduled, on January 2, 2026. Physicians' orders dated December 26 and 27, 2025, directed staff to perform the following: Staff were to administer 65 milliliters (mL) per hour of a tube feeding formula (Jevity 1.5) daily using an electrical feeding pump through Resident 1's feeding tube from 1:00 p.m. until 7:00 a.m. a total of 19 hours. Staff were to set the feeding tube pump to flush the feeding tube with 60 mL of water before and after each medication administration and feeding. Staff were to flush the feeding tube with 5 mL of water between medications and every shift. Review of Resident 1's January 2026 Treatment Administration Record (TAR) revealed there was no documented evidence that staff flushed the feeding tube on dayshift (7:00 a.m. to 3:00 p.m.) on January 2, 2026, or administered the tube feeding formula as ordered on January 2, 2026. Clinical record review revealed that Resident 4 had diagnoses that included dementia and depression. A physician's order dated October 1, 2025, directed staff to cleanse the resident's right hand's second and third digit finger with a saline solution, to apply an oil emulsion gauze, and wrap with a gauze dressing every day shift for wound care. Review of Resident 4's March 2026 TAR revealed there was no documented evidence that staff administered this treatment on March 12, 2026. Observations on March 16, 2026, at 10:38 a.m., and 2:20 p.m., revealed the resident had band aids on his fingers which were not the correct gauze dressing per the physician's order. In an interview on March 16, 2026, at 3:41 p.m., the Director of Nursing confirmed that there was no evidence that staff implemented the physician's orders as identified and the resident's hand wounds were covered with band aids, not gauze as ordered. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, clinical record review, observation, and staff interview, it was determined that the facility failed to provide treatment and services as ordered by the physician to promote healing and prevent new pressure sores for two of five sampled residents who had pressure sores. (Resident 2, 3) Findings include: Review of the facility's policy entitled Wound Management Protocols- Pressure Ulcers, dated January 2026, revealed that physician/wound consultant would determine the most appropriate treatment to manage a wound, and staff would refer to individual product package and physician order for detailed instructions for use in the care of pressure ulcers.Clinical record review revealed that Resident 2 had diagnoses that included a seizure disorder and metabolic encephalopathy (a brain dysfunction cause by metabolic disturbances leading to confusion, memory loss and altered consciousness). A review of Resident 2's admission skin assessment dated [DATE], revealed that the resident had a pressure sore on his sacrum and lower back. The Minimum Data Set (MDS) assessment, dated December 10, 2025, indicated that the resident required substantial assistance with overall care and that he had one pressure sore and six deep tissue injuries present on admission. A review of the care plan revealed that the resident had an actual skin breakdown. There was an intervention for staff to provide treatments as ordered by the physician. A review of physician's orders dated December 4, 2025, through February 11, 2026, revealed staff were directed to perform the following: Staff were to cleanse the sacral wound with a solution (normal saline), apply a dressing (Santyl), pack the wound with saline moistened gauze to the wound base, and cover with bordered foam dressing ever evening shift (3:00 p.m. to 11:00 p.m.) for wound care. Staff were to cleanse the right hip with a solution (normal saline), pat dry, apply a treatment (skin prep), and to leave open to air every evening shift for wound care. Staff were to cleanse the left hip with a solution (normal saline), apply a medicated dressing (Medihoney), and cover with a bordered gauze every evening shift for wound care. Staff were to cleanse the left lower back with a solution (normal saline), apply a dressing (Santyl), to pack with saline moistened gauze, and to cover with a bordered gauze every evening shift for wound care. Staff were to apply an ointment (Santyl) to wound areas topically every evening shift. Staff were to cleanse the right lower back with a solution (normal saline), apply a dressing (Medihoney), and to cover with a bordered gauze every evening shift for wound care. Staff were to cleanse the lower spine with a solution (normal saline), apply a dressing (Santyl), to pack with saline moistened gauze wrap, and to cover with a bordered gauze every evening shift for wound care. Staff were to cleanse the right plantar foot with a solution (normal saline), to cover with a medicated (betadine) moistened gauze, and cover with a padded dressing, and to wrap with gauze every evening shift for wound care. Review of the Treatment Administration Record (TAR) for December 2025, and January 2026 through March 2026, revealed there was no evidence that any of the wound treatments were completed as ordered to the resident's sacrum, right hip, left hip, left lower back, right lower back, and lower spine on December 12 and 28, 2025. There was no evidence that any of the wound treatments were completed as ordered on January 21, 25, and 31, 2026, and March 10, 2026. Clinical record review revealed that Resident 3 had diagnoses that included a sacral pressure ulcer and multiple sclerosis. A review of a wound care note dated March 16, 2026, revealed that the resident had a pressure sore on the sacrum. The MDS assessment dated [DATE], indicated that the resident had was cognitively intact and was dependent on staff for all care. A review of the care plan revealed that the resident had an actual wound on her sacrum and required assistance with all activities of daily living. There was an intervention for staff to provide treatments as ordered by the physician and for staff to reposition Resident 3 in bed. Review of a physicians' orders dated March 7, 2026, directed staff to apply black foam, a negative pressure wound therapy dressing cover, and attach to a wound therapy (a vacuum pump) running at 125 millimeters of mercury continuously to the resident's sacral wound. Staff were directed to change the dressing every Monday, Wednesday, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Friday, and as needed, and to check the placement and function of the negative pressure wound therapy setting every shift. Review of the TAR for March 2026, revealed that there was no documented evidence the treatment was functioning when staff checked it on the evening shift (3:00 p.m. to 11:00 p.m.) and night shift (11:00 p.m. to 7:00 a.m.) on March 15, 2026, or on the day shift (7:00 a.m. to 3:00 p.m.) on March 16, 2026. Observations on March 16, 2026, at 10:40 a.m., revealed the resident was flat on her back and the head of her bed was flat. A wound therapy pump was observed sitting on a bedside table. The pump was turned off and not connected to the resident. In an interview with Resident 3 during the observation period, she stated that the wound therapy system pump was not functioning, it had not been working since the afternoon on the previous day, and that staff does not reposition her. In an interview with Licensed Practical Nurse (LPN) 1 on March 16, 2025, at 11:05 a.m., LPN 1 stated the wound pump started beeping on the afternoon of March 15, 2026, when LPN 1 was assigned to care for Resident 3. LPN 1 could not find any problems with the machine. LPN 1 stated that she attempted to change the canister and tubing, but the facility did not have the correct supplies for this machine, so the machine was turned off and disconnected from Resident 3 at that time. Observation on March 16, 2026, at 2:20 p.m., revealed that Resident 3 was still lying flat on her back in bed. In an interview with Resident 3 at that time, she revealed that staff had not repositioned her since 10:40 a.m., and the resident wanted to be repositioned. In an interview on March 16, 2026, at 3:35 p.m., the Director of Nursing stated that there was no documented evidence that the treatments had been completed to the wounds for Resident 2, or that Resident 3 had been repositioned, and the wound therapy for Resident 3 had not been in place as it should have been per the physician's orders. 28 Pa. Code 211.12(d)(1)(5) Nursing services.