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	08/28/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on facility policy review, personnel file review, and staff interview, it was determined that the facility failed to verify professional license/registration status prior to the start of employment for two of five newly hired employees. (Employee 1 and Employee 2) Findings include:A review of the facility policy entitled, Abuse Policy- Prevention and Management, dated August 2024, revealed that the facility would conduct screening for all potential hires. This would include an inquiry to the state nurse aide registry, and they would record the results of the screening. Employee 1 (E1) had been working in the facility as a nurse aide since May 26, 2025, and an inquiry to the state nurse aide registry was not completed until August 27, 2025. Employee 2 (E2) had been working in the facility as a nurse aide since June 30, 2025, and an inquiry to the state nurse aide registry was not completed until August 27, 2025.In an interview on August 28, 2025, at 9:25 a.m., the Director of Nursing confirmed there was no documented evidence that the state nurse aide registry verification results for E1 and E2 were done prior to the start of employment per facility policy.28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.19(3) Personnel policies and procedures.

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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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and staff interview, it was determined that the facility failed to document an inventory of personal belonging on admission for one of 19 sample residents. (Resident 58)Findings include: Review of the facility policy entitled, Inventory/Personal Belongings, dated January 2025, revealed that a documented inventory of all residents' personal belongings was to be completed upon admission by the nursing department and that the inventory was to be kept in the clinical record. Clinical record review revealed that Resident 58 was admitted to the facility on [DATE]. There was no evidence in the clinical record that the facility documented an inventory of the resident's personal belongings. In an interview on August 28, 2025, at 9:30 a.m., the Director of Nursing confirmed that there was no documented inventory of the resident's personal belongings in the clinical record. 28 Pa Code 201.18(b)(2) Management. 28 Pa Code 201.24 (c) admission policy.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review and staff interview, it was determined that the facility failed to notify the resident and the resident's representative(s) of transfer(s), including the reasons for the moves, and Ombudsman information, in writing upon transfer and failed to provide copies of the written transfer notices to a representative of the Office of the State Long-Term Care Ombudsman for five out of five residents who were transferred out of the facility. (Residents 7, 11, 12, 13, and 51) Findings include:Clinical record review revealed that Resident 7 was transferred to the hospital on August 11, 2025, after a change in condition. There was no documented evidence to support that the resident and/or the resident's responsible party or legal representative was provided with written information regarding the transfer to the hospital and that the facility sent a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman.Clinical record review revealed that Resident 11 was transferred to the hospital on May 13, 2025, after a change in condition. There was no documented evidence to support that the resident and/or the resident's responsible party or legal representative was provided with written information regarding the transfer to the hospital and that the facility sent a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman.Clinical record review revealed that Resident 12 was transferred to the hospital on May 27, 2025, after a change in condition. There was no documented evidence to support that the resident and/or the resident's responsible party or legal representative was provided with written information regarding the transfer to the hospital and that the facility sent a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman.Clinical record review revealed that Resident 13 was transferred to the hospital on May 23, 2025, after a change in condition. There was no documented evidence to support that the resident and/or the resident's responsible party or legal representative was provided with written information regarding the transfer to the hospital and that the facility sent a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman. Clinical record review revealed that Resident 51 was transferred to the hospital on July 5, 2025, after a change in condition. There was no documented evidence to support that the resident and/or the resident's responsible party or legal representative was provided with written information regarding the transfer to the hospital and that the facility sent a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman.In an interview on August 28, 2025, at 12:10 p.m., the Director of Nursing confirmed that the notifications of transfer were not sent for these residents and resident representatives and that the written copies of the transfer notices were not sent to the Office of the State Long-Term Care Ombudsman.28 Pa. Code 201.14(a) Responsibility of licensee.

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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 and staff interview, it was determined that the facility failed to ensure that physician's orders were implemented for three of 19 sampled residents. (Residents 12, 51, and 100)Findings include: Clinical record review revealed that Resident 12 was admitted on [DATE], and had diagnoses that included peripheral vascular disease. On August 15, 2025, a physician ordered that staff obtain a blood test (a Complete Blood Count) on August 18, 2025. A review of Resident 12's clinical record revealed there was no documented evidence to support that the blood test was obtained as ordered. In an interview on August 28, 2025, at 9:29 a.m., the Director of Nursing confirmed that the ordered blood work was not done, and that nursing staff did not communicate the order to the laboratory. Clinical record review revealed that Resident 51 was admitted on [DATE], and had diagnoses that included chronic kidney disease, failure to thrive, and congestive heart failure. On August 2, 2025, a physician ordered that staff weigh the resident every day. A review of Resident 51's weights revealed that there was no documented evidence to support that staff weighed the resident on August 3, 4, 5, 6, 9, 10, 13, 16, 17, 18, 22, and 23, 2025. Clinical record review revealed that Resident 100 was admitted on [DATE], and had diagnoses that included liver cell cancer and edema. On June 28, 2025, a physician ordered that staff weigh the resident every day. A review of Resident 100's weights revealed that there was no documented evidence to support that staff weighed the resident on July 4 and 6, 2025, and August 4, 10, 12, 16, and 20, 2025. In an interview on August 28, 2025, at 9:10 a.m., the Director of Nursing confirmed that there was no documentation to support that staff weighed Residents 51 and 100 as ordered by the physician. CFR 483.25 Quality of CarePreviously cited 10/24/24 28 Pa. Code 211.12(d)(1)(5) Nursing services.