

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395292	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/16/2024
NAME OF PROVIDER OR SUPPLIER Wesbury United Methodist Commu		STREET ADDRESS, CITY, STATE, ZIP CODE 31 North Park Ave Ext Meadville, PA 16335	

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)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47356</p> <p>Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to review and revise comprehensive care plans to reflect the current care and services for three of 26 residents reviewed (Residents R27, R88, and R100).</p> <p>Findings include:</p> <p>A facility policy entitled, Care Plans, plans of service dated 7/2024, indicated Care plans are updated whenever a change is necessitated by a resident's change in condition, physician orders, or when scheduled by the MDS (Minimum Data Set- standardized assessment tool that measures health status in nursing home residents) team for a quarterly, change in condition, or annual review.</p> <p>Resident R27's clinical record revealed an admitted [DATE], with diagnoses that included hypothyroidism (a condition when the thyroid produces low amounts of thyroid hormones), and diabetes (a health condition that caused by the body's inability to produce enough insulin).</p> <p>Resident R27's clinical record revealed the last care plan meeting note was dated 5/9/24.</p> <p>Resident R27's care plan revealed a goal date of 8/7/24, indicating that the care plan had not been reviewed and revised to reflect the current care and services.</p> <p>Resident R88's clinical record revealed an admitted [DATE], with diagnoses that included diabetes and hypertension (high blood pressure).</p> <p>Resident R88's clinical record revealed a late entry for the last care plan meeting note dated 8/15/24.</p> <p>Resident R88's care plan revealed a goal date of 7/25/24, indicating that the care plan had not been reviewed and revised to reflect the current care and services.</p> <p>Resident R100's clinical record revealed an admitted [DATE], with diagnoses that included dysphagia (trouble swallowing), difficulty in walking, and muscle weakness.</p> <p>Resident R100's clinical record revealed the last care plan note was a late entry dated 5/10/24, for a 5/03/24 care plan meeting.</p> <p>(continued on next page)</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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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident R100's care plan revealed a goal date of 8/1/24, indicating that the care plan had not been reviewed and revised to reflect the current care and services.</p> <p>During an interview on 8/16/24, at 10:30 a.m. the Director of Nursing confirmed that the care plans for Residents R27, R88, and R100 were not reviewed and revised timely to reflect current resident care and services.</p> <p>28 Pa. Code 211.10(c)(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47356</p> <p>Based on review of facility policy and clinical records, observation, and staff interview, it was determined that the facility failed to obtain a physician's order for the provision of oxygen therapy for one of two residents reviewed for respiratory services (Resident R123).</p> <p>Findings include:</p> <p>Review of facility policy with a policy review date of 6/2024, entitled Oxygen Therapy and Equipment indicated Purpose: to administer oxygen when insufficient O2 (Oxygen) being carried by the blood to the tissues. All residents using Oxygen will be monitored for safe and effective use of Oxygen therapy. Oxygen may be administered as a nursing measure without physician order. Physician to be notified and order received.</p> <p>Resident R123's clinical record revealed an admitted [DATE], with diagnoses that included gastrostomy (surgical procedure that creates an artificial opening into the stomach for nutritional support) complication, contracture (permanent or temporary tightening of muscles, tendons, skin, and nearby tissues that cause joints to shorten and become stiff preventing normal movement) of the left and right hand, and history of a cerebral infarction (area of brain tissue that dies as a result of lack of blood and oxygen).</p> <p>Observation on 8/16/2024, at 12:00 p.m. and on 8/14/2024, at 9:42 a.m. revealed Resident R123 wearing an oxygen nasal cannula (a thin tube with two prongs that fits into the resident's nostrils to deliver oxygen) connected to an oxygen concentrator delivering 2 liters per min (lpm - a unit of oxygen flow [NAME] that is delivered to the resident).</p> <p>Resident R123's clinical record revealed an order from 7/20/2023, that reads, assess for O2 use every shift. The clinical record lacked evidence of a physician's order for how much oxygen to deliver.</p> <p>During an interview on 8/16/2024, at 12:30 p.m. the Director of Nursing confirmed that Resident R123 was being administered oxygen therapy and their clinical record lacked a physician's order for the specific oxygen therapy.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing service</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47356</p> <p>Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to have the required 14-day stop date or provide a clinical rationale for the continued use of a PRN (as needed) psychotropic (affecting the mind) medication beyond 14 days for one of 26 residents reviewed (Resident R29).</p> <p>Findings include:</p> <p>A facility policy entitled Psychopharmacological Medication Dosage Reductions dated 7/2024, revealed that Psychotropic medications excluding antipsychotics ordered prn may only be prescribed for a 14-day duration. If the physician or prescribing practitioner wishes to extend the order beyond 14 days, they should document the rationale for the extended time period in the medical record and indicate a specific duration.</p> <p>Resident R29's clinical record revealed an admitted [DATE], with diagnoses that included anxiety, dementia (impaired ability to remember, think, and make decisions), and muscle weakness. A physician's order dated 8/02/24, identified to administer Lorazepam (anti-anxiety) 0.5 milligrams (mg) by mouth every 4 hours as needed for anxiety, and lacked the required stop date within 14 days or a clinical rationale for continued use beyond 14 days.</p> <p>During an interview on 8/15/24, at 12:28 p.m. the Director of Nursing confirmed that Resident R29's Lorazepam orders lacked the required stop date within 14 days or a clinical rationale for continued use beyond 14 days.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47356</p> <p>Based on review of facility policy and manufacturer's recommendations, observations, and staff interview, it was determined that the facility failed to ensure an expired medication was discarded in a timely manner in one of two medication rooms reviewed (College Way medication room).</p> <p>Findings include:</p> <p>Review of a facility policy entitled Medications, Multidose Vials dated [DATE], indicated Medications may be used until the manufacturer's expiration date or the length of time allowed by state law. When a vial/dispenser has exceeded either expiration date the medication is to be disposed of per facility policy and reordered.</p> <p>Manufacturer's recommendations for Tubersol PPD (solution used for tuberculosis testing upon admission and for employment), indicated that vials which are entered and in use for 30 days should be discarded.</p> <p>Observations of drug storage on [DATE], at approximately 2:34 p.m. in College Way medication room's refrigerator revealed an opened vial of Tubersol with an open date of [DATE].</p> <p>During an interview at that time Licensed Practical Nurse Employee E1 confirmed that the Tubersol vial's open date was past 30 days and the expired medication should have been discarded.</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy services</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47356</p> <p>Based on review of facility policy and clinical record, observations, and staff interview, it was determined that the facility failed to implement infection control practices regarding Enhanced Barrier Precautions (EBPs-additional infection control precautions put in place for individuals who have an increased risk of multi-drug resistant organisms (MDROs) or who are colonized/infected with MDROs) for a gastric feeding tube (a medical device used to provide nutrition and/or medications when a person cannot swallow or take anything by mouth) for one of 26 residents reviewed (Resident R123).</p> <p>Findings include:</p> <p>Review of the facility policy entitled Enhanced Barrier Precautions implemented 3/2024, indicated that all staff providing direct resident care will adhere to EBPs, in addition to standard precautions, when performing high-contact resident care activities for residents with wounds, indwelling medical devices, and/or suspected or confirmed infection or colonization of certain MDROs. EBP's are designed to reduce transmission of resistant organisms and expands the use of gown and gloves during high-contact resident care activities that are opportunities for transfer of MDROs to staff hands and clothing when Contact Precautions do not otherwise apply to residents with wounds or indwelling medical devices (urinary catheters, vascular access devices, tracheostomies, feeding tubes and wound drains), regardless of MDRO status.</p> <p>Resident R123's clinical record revealed an admitted [DATE], with diagnoses that included dysphagia (difficulty swallowing), gastrostomy complications (complication with gastric feeding tube), and muscle weakness.</p> <p>Observations made prior to a gastric feeding tube medication administration for Resident R123 on 8/14/24, at approximately 11:15 a.m. revealed that there were not any EBPs in place.</p> <p>During an interview at that time the Infection Preventionist confirmed that EBPs were not in place and employees should be wearing gloves and gowns when working with gastric feeding tubes.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		