

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395300	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER Wexford Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9850 Old Perry Highway Wexford, PA 15090	

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 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>27424</p> <p>Based on review of facility policy, resident council minutes, group and staff interview it was determined that the facility failed to respond to resident concerns and grievances identified during resident council meeting for six of six months reviewed (May 2024 to October 2024).</p> <p>Findings include:</p> <p>Review of facility policy dated 10/24/24, Resident Grievance indicated: Grievance: an official statement of a complaint over something believed to be wrong or unfair.</p> <p>Review of Resident Council minutes from May 2024 to October 2024 indicated the following concerns:</p> <p>5/7/24: call bells, 3/11 staff not giving good care, and staff not wearing name tags.</p> <p>6/4/24: agency aides don't know residents and are rude, want to know staff to resident ratio, why don't wear name tags and introduce themselves, and staff don't wear name tags.</p> <p>7/2/24: shortage in linens not smelling fresh, not enough oxygen on nursing unit, agency aides not answering call bells.</p> <p>8/6/24: shortage in linen, vending machine that accepts credit cards, staff not wearing name tags.</p> <p>9/3/24: vending machine that accepts credit cards, staff not wearing name tags, oxygen tanks on floors, some residents not getting showers.</p> <p>10/1/24: vending machine that accepts credit cards, staff wearing name tags and evening activities.</p> <p>Resident group meeting on 10/30/24, at 11:35 a.m. residents (total group) agreed that their concerns are on-going, they do not get answers or resolutions to their concerns but are told the facility is working on their concerns.</p> <p>During an interview on 10/31/24, at 8:45 a.m. Activity Director Employee E9, confirmed that there was no documentation to be provided for follow up of residents' concerns from resident council meetings, and that the facility failed to respond to resident concerns and grievances identified during resident council.</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 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>28 Pa. Code 201.18(b)(1) Management.</p>

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<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Let each resident or the resident's legal representative access or purchase copies of all the resident's records.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27424</p> <p>Based on facility policy, resident representative and staff interview it was determined that the facility failed to provide medical record access for one of four residents (Closed Resident Record R177).</p> <p>Findings include:</p> <p>Review of Resident Rights dated 10/24/24, indicated: Residents have the right to access all resident records, including clinical records (medical records and reports) promptly. The residents legal guardian has the right to look at all of the residents medical records and make important decisions on the residents behalf/</p> <p>Facility documentation indicated Closed Record Resident R177 was admitted on [DATE].</p> <p>Facility documentation indicated Closed Record Resident R177 had diagnosis of unspecified dementia, anxiety disorder, and cognitive communication deficient. Which remained current as of the MDS (minimum data set a periodic assessment of basic needs) on 8/13/24.</p> <p>Review of Closed Resident Record R177 progress notes indicated contact with the financial POA for medical decisions on the following days:</p> <p>9/8/24 - facility called Power of Attorney (POA) asking if they wanted the Closed Record Resident to be sent out for further surgical evaluation, or to control her pain here, opted to send out to hospital for further investigation- 911 called and Director of Nursing (DON) notified.</p> <p>9/8/24 - family was resident sent out.</p> <p>9/8/24 - 2nd contact notified (listed as friend on admit sheet) regarding swollen and bruised ankle.</p> <p>8/13/24 - notified Closed Record Resident R177 POA about weight gain.</p> <p>8/8/24- left voice mail for POA about weight change.</p> <p>Phone interview on 10/31/24, at 1:15 p.m. Closed Record Resident R177 POA indicated the following she was and (still currently) the financial POA and had been since 2013, the facility contacted her to make medical and financial decision to include when she was sent out to the hospital. Closed record Resident R177 POA requested CR Resident R177 clinical records but was told she could not have the records. The facility did not assist the POA with getting the medical POA.</p> <p>During an interview on 10/31/24, at 1:40 p.m the following was confirmed by Corporate Employee E35, that the facility did use the financial POA as responsible party to make medical decisions for Closed Record Resident R177, and the facility was aware of the request, but did not give the records to the POA. The facility failed to provide medical record access to Closed Record resident R177 POA.</p> <p>(continued on next page)</p>		

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<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa. Code 201.29(a)Resident rights.</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075</p> <p>Based on review of facility documents, facility policy, clinical records, resident representative interview, and staff interviews, it was determined that the facility failed to provide appropriate goods and services to prevent physical neglect for two of four residents (Resident R87 and R107).</p> <p>Findings include:</p> <p>Review of facility Abuse, Neglect and Misappropriation policy dated 9/9/23 and 10/24/24, indicated it is the policy of the facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. It is the intent of the facility to prevent abuse, mistreatment, or neglect of residents or the misappropriation of their property, corporal punishment and involuntary seclusion and to provide guidance to direct staff to manage any concerns or allegations of abuse, neglect or misappropriation of their property.</p> <p>Review of the clinical record indicated Resident R87 was admitted to the facility on [DATE].</p> <p>Review of Resident R87's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/27/24, indicated diagnoses of high blood pressure, depression, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Section GG0130 is coded as a 1, indicating dependent for toileting hygiene.</p> <p>Review of Resident R87's care plan dated 9/30/24, indicated toileting hygiene - Dependent. Helper does all of the effort or two or more helper assists.</p> <p>During an interview on 10/27/24, at 12:26 p.m. a resident representative reported an allegation of neglect to State Agency concerning incontinent care being completed timely and that evening shift is the worse shift. During allegation of neglect, it was reported that resident was not changed for nine hours on 10/16/24.</p> <p>During an interview on 10/27/24, at 1:15 p.m. the Nursing Home Administrator stated he was familiar with the neglect allegation and was able to provide documentation dated 10/17/24, regarding the investigation that was conducted related to the event.</p> <p>During review of documentation provided by the facility on 10/28/24, at 10:35 a.m. indicated that the resident was observed to have been incontinent. This was observed by resident representative and other staff members once it was brought to their attention. The incident was discussed with the employee assigned to resident in which she responded, I had not changed her since earlier in the morning.</p> <p>During review of documentation provided by the facility on 10/28/24, at 11:02 a.m. indicated that the facility substantiated the allegation of neglect that was made for Resident R87.</p> <p>During an interview on 10/30/24, at 10:15 a.m. Nursing Home Administer (NHA) stated We did the investigation and the alleged perpetrator resigned from the facility.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/30/24, at 10:37 a.m. NHA confirmed that the facility failed to ensure that residents were free from neglect for Resident R87.</p> <p>Review of the clinical record revealed that Resident R107 was admitted to the facility on [DATE].</p> <p>Review of Resident 107's MDS dated [DATE], indicated diagnoses of high blood pressure, intracerebral hemorrhage (when a ruptured blood vessel causes bleeding inside the brain), and dysphagia (difficulty swallowing).</p> <p>Review of Resident R107's clinical record revealed a progress note from Physician Assistant (PA) Employee E34 dated 10/30/24, at 5:36 p.m. that stated the following: Very critical K (potassium level) in a non-verbal patient. Full code. Will transfer to ER (emergency room). K was 5.5 on the 10/29/24, now 6.8. Transfer to ER.</p> <p>Review of Resident R107's clinical record revealed a nursing progress note dated 10/31/24, at 9:20 a.m. that stated the following: To go into ER due to elevated potassium.</p> <p>During an observation on 10/31/24, at approximately 9:30 a.m. State Agency witnessed Resident R107 being transferred into an ambulance.</p> <p>During an interview on 10/31/24, at 12:53 p.m. PA Employee E34 stated that she had been contacted the evening of 10/30/24, regarding Resident R107's high potassium level via a telehealth visit in which she instructed the nurse who contacted her to send Resident R107 to the hospital. When PA Employee E34 was asked if she meant for Resident R107 to be sent to the hospital the following morning, she replied No. I wanted her sent out right then. PA Employee E34 added that the conversation with facility staff and the contents of the consult are recorded and that there are audio files to support her instructions.</p> <p>During an interview on 10/31/24, at 2:22 p.m. the Director of Nursing (DON) confirmed that Resident R107 was not sent out to the hospital on the evening of 10/30/24, as instructed, and that the expectation would have been to send Resident R107 to hospital directly after having received the order to do so. DON confirmed that the facility neglected to address Resident R107's change in condition in a timely manner.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee</p> <p>28. Pa Code 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code 201.29(j) Resident rights.</p> <p>28. Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785</p> <p>Based on review of clinical records and observations, as well as staff and resident interviews, it was determined that the facility failed to provide Activity of Daily Living (ADL) assistance for four out of nine sampled residents (Resident R27, R46, R48, and R87).</p> <p>Findings include:</p> <p>The facility Routine resident care policy dated 9/19/23, indicated that routine resident care is not necessarily clinical, but is necessary for quality of life. Provide routine daily care by a certified nursing assistant. Routine care includes but is not limited to the following: bathing, dressing and toileting.</p> <p>Review of Resident R27's admission record indicated he was originally admitted on [DATE], and readmitted on [DATE].</p> <p>Review of Resident R27's MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 6/18/24, indicated that he had diagnoses that included diabetes (a metabolic disorder impacting organ function related to glucose levels in the human body), peripheral vascular disease (PVD- a narrowing of the blood vessels in the legs), hypertensive heart disease (a condition characterized by long term heart conditions and high blood pressure), anxiety disorder (a medical condition creating a sense of acute fear, restlessness, and worry), and spinal stenosis (a narrowing of the spaces within the spine, which causes pain and weakness). The diagnoses were current upon review.</p> <p>Review of Resident R27's MDS assessment dated [DATE], indicated that Section GG0100A-Self care (resident's need for assistance with bathing, dressing, using the toilet) was coded 2 for help needed from another person.</p> <p>Review of Resident R27's care plan dated 6/20/24, indicated that Resident R27 was dependent for shower/bathe. Helper does all of the effort with two or more staff.</p> <p>Review of Resident R27's October 2024 shower documentation indicated there was no shower provided on 10/2/24, 10/26/24, and 10/30/24.</p> <p>During an interview on 10/27/24, at 1:10 p.m. Resident R27 was interviewed and stated the following: I never had my beard trimmed. The Nurse aide did not get me a shower last night and they do not want to do showers.</p> <p>Review of clinical record indicated that Resident R46 was admitted on [DATE].</p> <p>Review of Resident R46's MDS dated [DATE], indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and muscle weakness.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R46's MDS assessment dated [DATE], indicated that Section GG0100A-Self-care (resident's need for assistance with bathing, dressing, using the toilet) was coded 2 for help needed from another person.</p> <p>Review of Resident R46's care plan dated 9/10/24, indicated that Resident R46 was dependent for shower/bathe. Helper does all of the effort with assistance of one person.</p> <p>Review of Resident R46's October 2024 shower documentation indicated there was no shower provided on 10/10/24, 10/14/24, and 10/28/24.</p> <p>Review of the clinical record indicated Resident R48 was admitted to the facility on [DATE].</p> <p>Review of Resident R48's MDS dated [DATE], indicated diagnoses of neurogenic bladder (bladder problems due to disease or injury of the nervous system involved in the control of urination), and quadriplegia (paralysis of all four limbs). Section GG - Functional Abilities and Goals, Question GG01130E - Shower/bathe self: indicated Resident R48 was coded 1 dependent, helper does all of the effort.</p> <p>Review of Resident R48's care plan dated 6/4/24, indicated that Resident R48 was dependent for shower/bathe. Helper does all of the effort with two or more staff.</p> <p>Review of Resident R48's October 2024 shower documentation indicated there was no shower or bath provided on 10/3/24, 10/7/24, 10/10/24, 10/14/24, 10/21/24, 10/24/24, and 10/28/24.</p> <p>During an interview on 10/27/24, at 10:18 a.m. Resident R48 stated, I go three weeks without getting a shower. I'm supposed to get showers on Mondays and Thursdays, I have never gotten a shower twice a week here.</p> <p>Review of Resident R87's admission record indicated he was admitted to the facility on [DATE].</p> <p>Review of Resident R87's MDS dated [DATE], indicated diagnoses of high blood pressure, depression, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life).</p> <p>Review of Resident R87's care plan dated 9/30/24, indicated that Resident R87 was dependent for shower/bathe. Helper does all of the effort with two or more staff.</p> <p>Review of Resident R87's September 2024 shower documentation indicated no showers were provided since admission.</p> <p>Review of Resident R87's October 2024 shower documentation indicated no shower was provided on 10/3/2024, 10/10/2024, 10/17/2024, 10/21/24, 10/24/24, and 10/28/24.</p> <p>During an interview on 10/30/24, at 2:52 p.m the Director of Nursing (DON) confirmed that the facility failed to provide Activity of Daily Living (ADL) assistance for Residents R27, R46, R48, and R87, as required.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18(e)(6) Management.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>28 Pa. Code: 211.12(a)(c)(d)(1)(2)(3)(4) Nursing services.</p> <p>28 Pa. Code: 201.20 Staff development.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27424</p> <p>Based on review of facility policy, clinical record review and staff interview it was determined that the facility failed to make certain that residents are free from significant medication errors for two of eight residents (Resident R73 and R173).</p> <p>Findings include:</p> <p>Review of facility policy Missed Medication/Medication Error dated 10/24/24, indicated the following: Medication error/incident - any physician/provider prescribed medication that is not administered to the resident as prescribed regardless of the category or the reason for not providing the medication.</p> <p>Review of manufactures of guidelines for Trulicity (a type 2 diabetes medication that helps your body release own insulin - given weekly) indicated: Recommendations regarding missed dose - If a dose is missed, instruct patients to administer the dose as soon as possible if there are at least 3 days (72 hours) until the next scheduled dose.</p> <p>Review of the clinical record indicated Resident R73 was admitted to the facility on [DATE].</p> <p>Review of Resident R73 MDS assessment (Minimum Data Set - a periodic assessment of resident care needs) dated 5/22/24, indicated the diagnosis of epilepsy/seizure disorder (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), psychotic disorder (a mental disorder characterized by a disconnection from reality) and mastocytosis (a rare disorder characterized by abnormal accumulation and activation of mast cells in the skin, bone marrow and internal organ).</p> <p>Review of Resident R73 clinical record indicated the following:</p> <p>10/29/24 Cromolyn Sodium (a medication used to prevent the release of substances in the body that cause inflammation) Oral Concentrate MG (milligrams)/5ML (milliliters) Give 15 ml by mouth four times a day for mastocytosis: medication on order, will administer once available - this was documented at 22:45, 17:35, 13:48, and 8:06.</p> <p>10/28/24 Cromolyn Sodium Oral Concentrate MG/5ML Give 15ml by mouth four times a day for mastocytosis - Med not available in house.</p> <p>10/23/24 Cromolyn Sodium Oral Concentrate MG/5ML Give 15ml by mouth four times a day for mastocytosis - request for refill sent ot pharmacy waiting for supply from the pharmacy.</p> <p>10/16/24 Cromolyn Sodium Nasal Aerosol Solution 5.2 MG/ACT 1 spray in each nostril four times a day for mastocytosis 12:07 - Meds not available.</p> <p>During an interview on 10/29/24, at 9:27 a.m. Resident R73 said that she/he has missed medications doesn't feel as well as when she/he gets medications as ordered.</p> <p>Resident R173 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R173 admit sheet indicated diagnosis of type II Diabetes Mellitus (chronic disease that occurs when the body doesn't use insulin properly, resulting in high blood sugar levels), and end stage renal dependence (a permanent condition that occurs when the kidneys are no longer able to function).</p> <p>Review of clinical progress notes dated 10/19/24, indicated Trulicity Subcutaneous Solution Pen-injector 0.75MG/0.5ML Inject .75mg subcutaneously one time a week every Saturday for DM (diabetes mellitus) - medication not available in house, called Pharmacy script syringe to be delivered soon as possible.</p> <p>Review of Resident R173 clinical record failed to show where medication was given.</p> <p>Review of Resident R173 record failed to indicate the physician was notified.</p> <p>During an interview on 10/31/24, at 2:22 p.m. Director of Nursing confirmed that Resident R73 and Resident R173 had missed ordered medication and that the facility failed to get the medication to the residents as ordered and this led to the significant medication error.</p> <p>28 Pa. Code 211.3(a)(b)(c)(d)e(1)(2)(3)(4) Verbal and telephone orders.</p>