STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395332	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wayne Center	30 West Avenue Wayne, PA 19087

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review it was determined that the facility failed to hold care plan meetings with the required members of the interdisciplinary team for one out of eight residents reviewed (Resident 9).Findings include:Review of Resident 9's quarterly MDS assessment (Minimum Data Set - a mandatory assessment of resident care needs and medical condition) dated May 13, 2026, revealed Resident 9 was cognitively intact and their own representative. Resident 9 was totally dependent on facility staff to complete activities of daily living and dependent on facility staff for mobility. Resident 9 was totally dependent on facility staff to get out of bed.Review of clinical records revealed that Resident 9 had quarterly MDS assessments on May 13, 2026, February 13, 2026, September 5, 2025, and a significant change (a decline or improvement affecting multiple health areas and requiring an interdisciplinary care-plan revision) MDS assessment on November 14, 2025. Further review of clinical records failed to reveal that an interdisciplinary care plan meeting occurred after those assessments or that the resident had been invited to any care plan meetings or interdisciplinary team meetings.Interview with Resident 9 on March 24, 2026, at approximately 11:00 a.m. revealed that Resident 9 did not participate in care plan meetings because since I can't get out of bed, I can't attend.Interview with the Licensed Clinical Social Worker on June 25, 2026, at approximately 11:35 a.m. revealed that care plan meetings had not been held on a regular basis.Review of the nurse practitioner encounter notes dated January 6, 2026, revealed that the reason for the encounter was annual comprehensive evaluation. Outcome of the encounter was shared with Resident 9, the RN (Registered Nurse) unit manager, physical therapy, Resident 9's emergency contact, Resident 9's primary care physician via email, and the cardiologist. There was no evidence that members of the social work, behavioral health, activities, or dietary team were included in the outcomes of the encounter.Review of encounter notes dated March 27, 2026, revealed that the reason for the encounter was warmth, and erythema (redness) of rt (right) leg. Outcome of the encounter was communicated to the primary care provider and the RN unit manager. There was no evidence that members of the social work, behavioral health, activities, or dietary team were included in the outcomes of the encounter.Review of encounter notes dated April 17, 2026, revealed that the reason for the encounter was routine follow up of chronic medical conditions. Outcome of the encounter was communicated to Resident 9's emergency contact, the primary care provider, the LPN (licensed practical nurse), the RN unit manager, occupational and physical therapy, behavioral health, wound team, and pulmonologist. There was no evidence that members of the social work, activities, or dietary team were included in outcomes of the encounter.Interview with the Director of Nursing on June 26, 2026, at approximately 10:30 a.m. revealed that Resident 9 was under the care of a nurse practitioner who was having their own interdisciplinary team meetings in place of care plan meetings with the facility interdisciplinary team. 28 Pa. Code 211.12(d)(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on policy reviews, clinical records review and staff interviews, it was determined that the facility failed to develop physician orders regarding respiratory care for one of one resident's reviewed (Resident 117). Findings Include:Review of Resident 117's diagnosis list revealed chronic obstructive pulmonary disease, unspecified (a common lung disease causing restricted airflow and breathing problems).Observations of Resident 117 on June 23, 2026, at 10:40am; June 24, 2026, at 1:15pm and June 25, 2026, at 10:20am revealed resident was receiving oxygen at 2L/min via Nasal Cannula (tube inserted into the nose to deliver extra oxygen).Review of Resident 117 physician orders failed to reveal orders for oxygen therapy including method of administration, volume to be administered, or frequency of administration.Interview with Licensed Nurse Employee E3 on June 25, 2026, at 10:29am confirmed that resident does not have an order for oxygen therapy.Interview with Director of Nursing on June 25, 2026, at 11:00am confirmed the above findings.28 Pa code: 211.12(d)(1)(3)(5) Nursing services