

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER West Reading Skilled Nursing and Rehabilitation Ce		STREET ADDRESS, CITY, STATE, ZIP CODE 425 Buttonwood Street West 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide assistance with dining in a manner that promoted and maintained dignity for one of 31 sampled residents. (Resident 3) Findings include: Clinical record review revealed that Resident 3 had diagnoses that included muscle wasting, dysphagia (difficulty in swallowing), protein-calorie malnutrition, and history of a traumatic brain injury. Review of the Minimum Data Set (MDS) assessment, dated December 19, 2025, revealed that the resident had significant cognitive impairment and required staff assistance with eating. Review of Resident 3's care plan revealed that staff was to assist the resident with meals as needed, encourage the resident to take small bites, provide verbal cues to take frequent drinks, and check for food in the mouth after swallowing. On January 28, 2026, from 12:25 p.m. through 12:40 p.m., licensed practical nurse (LPN) 1 was observed standing while assisting Resident 3 with lunch. In an interview on January 29, 2026, at 11:00 a.m., the Director of Nursing stated that staff should not stand when feeding residents. CFR 483.10 (a)(1) Resident Rights Previously Cited 2/18/25 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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 395351	If continuation sheet Page 1 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER West Reading Skilled Nursing and Rehabilitation Ce		STREET ADDRESS, CITY, STATE, ZIP CODE 425 Buttonwood Street West 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)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**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 the Minimum Data Set (MDS) assessment was completed to accurately reflect the current status of three of 31 sampled residents. (Residents 1, 10, 13) Findings include:</p> <p>Clinical record review revealed that Resident 1 received oxygen therapy starting on September 25, 2025. The MDS assessment dated [DATE], incorrectly indicated in Section O (Special treatments, Procedures, Programs) that the resident was not receiving oxygen therapy during the previous seven days.</p> <p>In an interview on January 29, 2026, at 10:50 a.m., the Director of Nursing confirmed that Resident 1's MDS assessment was inaccurate.</p> <p>Clinical record review revealed that Resident 10 had diagnoses that included hepatic (liver) failure and asthma. Review of Resident 10's MDS dated [DATE], indicated that Resident 10 received an anticoagulant medication. Review of Resident 10's clinical record revealed no physician's orders for an anticoagulant medication.</p> <p>Clinical record review revealed that Resident 13 had diagnoses that included cerebrovascular disease (affects blood vessels in the brain) and bipolar disorder. Review of Resident 13's MDS dated [DATE], indicated that Resident 13 received an anticoagulant medication. Review of Resident 13's clinical record revealed no physician's orders for an anticoagulant medication.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER West Reading Skilled Nursing and Rehabilitation Ce		STREET ADDRESS, CITY, STATE, ZIP CODE 425 Buttonwood Street West 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to implement physicians' orders for two of 31 sampled residents. (Residents 1 and 30) Findings include:</p> <p>Clinical record review revealed that Resident 1 had diagnoses that included hypertension (high blood pressure) and renal dialysis. A physician's order dated December 12, 2025, directed staff to administer a blood pressure medication (midodrine) three times a day on Tuesday, Thursday, Saturday, and Sunday and two times a day on Monday, Wednesday, and Friday. The physician ordered that staff were not to administer the medication if the resident's systolic blood pressure (SBP, the first measurement of blood pressure when the heart beats and the pressure is at its highest) was greater than 130 millimeters of mercury (mm/Hg). Review of Resident 1's Medication Administration Records (MARs) for December 2025 and January 2026, revealed that staff administered midodrine three times in December and four times in January when Resident 1's SBP was greater than 130mm/Hg.</p> <p>Clinical record review revealed that Resident 30 had diagnoses that included hypotension (low blood pressure), chronic respiratory failure, and peripheral vascular disease. A physician's order dated May 15, 2025, directed staff to administer a blood pressure medication (midodrine) three times a day. The physician ordered that staff were not to administer the medication if the resident's SBP was greater than 120 mm/Hg. Review of Resident 30's MARs for October, November, and December 2025, and January 2026, revealed that staff administered midodrine 28 times in October, 39 times in November, 26 times in December, and two times in January when Resident 30's SBP was greater than 120mm/Hg.</p> <p>In an interview on January 29, 2026, at 10:44 a.m., the Director of Nursing confirmed that the medications were administered outside of parameters ordered by the physicians for Residents 1 and 30.</p> <p>CFR 483.25 Quality of Care Previously cited 12/10/24</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER West Reading Skilled Nursing and Rehabilitation Ce		STREET ADDRESS, CITY, STATE, ZIP CODE 425 Buttonwood Street West 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)		
<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>Based on facility policy review, clinical record review, observation, and staff interview, it was determined that the facility failed to follow policies and procedures to prevent the spread of infection for one of 31 sampled residents. (Resident 113) Findings include: Review of the facility policy entitled, Enhanced Barrier Precautions, (EBP) last reviewed November 14, 2025, revealed that enhanced barrier precautions were to be used with any resident with an indwelling medical device when contact is expected. Precautions included the use of protective gowns during the high risk activities and staff were to be trained on what was considered high risk activity. Clinical record review revealed that Resident 113 had diagnoses that included a stroke and dysphagia (difficulty in swallowing), and had a gastrostomy tube (a tube to deliver nutrition, fluids, or medication directly into the stomach) in place. Review of the Minimum Data Set assessment, dated November 3, 2025, revealed that the resident had significant cognitive impairment and had a feeding tube. Review of Resident 113's care plan revealed that the staff were to follow EBP when providing personal care and when handling the feeding tube. On January 27, 2026, at 10:30 a.m., a sign was observed on the wall outside Resident 113's room indicating that staff were to follow Enhanced Barrier Precautions when providing high contact direct-care, including providing hygiene and feeding tube device care. At that time, Licensed Practical Nurse 1 (LPN 1) was observed sitting on Resident 113's bed, not wearing a protective gown while providing care to the resident's feeding tube. On the same day from 10:31 a.m. to 10:41 a.m. LPN 1 and Nurse Aide 2 (NA 2) provided hygiene care to Resident 113 while not wearing gowns. In an interview on January 27, 2026, at 10:45 a.m., NA 2 confirmed that she and LPN 1 were providing hygiene care to Resident 113. In an interview on January 29, 2026, at 11:03 a.m., the Director of Nursing stated that staff should have worn gowns when providing care to Resident 113. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER West Reading Skilled Nursing and Rehabilitation Ce		STREET ADDRESS, CITY, STATE, ZIP CODE 425 Buttonwood Street West 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)		
<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>Based on a review of facility policy, observation, and staff interview, it was determined that the facility failed to maintain a fully functioning resident call bell system for one of 31 sampled residents. (Resident 30). Findings include: Review of the facility policy NSG Call Lights, dated November 15, 2025, revealed the statement, Patients will have a call light or alternative communication device at each patient's bedside, toilet, and bathing room to allow patients to call for assistance when unattended. Observation on January 27, 2026, at 11:27 a.m., revealed the call light failed to light and the signal failed to sound at the nurse's station when the button on the cord at Resident 30's bed was pressed. During an interview at 11:45 a.m., Nurse Aide 1 (NA 1) confirmed the cord was damaged and required replacement. During an interview on January 28, 2026, at 1:30 p.m., the Administrator confirmed that the facility failed to maintain a fully functioning resident call bell system in one room. 28 PA Code 201.14(a) Responsibility of licensee. 28 Pa Code 205.28 (c)(1) Nurses' station.</p>		