STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395602	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wesley Village	209 Roberts Road Pittston, PA 18640

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 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** 26142 Based on clinical record review and staff interview, it was determined that the facility failed to provide prescribed treatment necessary to manage constipation and promote normal bowel activity to prevent related complications and demonstrate timely and thorough assessment of a resident for one resident out of seven sampled (Resident 1). Findings include: According to the American Academy of Family Physicians {The American Academy of Family Physicians is one of the largest medical organizations in the US founded to promote the science and art of family medicine}the primary goal of constipation management should be symptom improvement, and the secondary goal should be the passage of soft, formed stool without straining at least three times per week). A review of the clinical record revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses to include stage 3 kidney disease, urinary retention, a history of constipation and fecal impaction and anxiety. An admission history and physical dated January 17, 2024, completed prior to the resident's the facility revealed that she was hospitalized for multiple health issues to include having severe constipation, not having a bowel movement at home for 2 weeks. She had a fecal impaction, was disimpacted and Miralax (laxative) daily was initiated. An admission MDS Assesment (Minimum Data Set - a federally mandated standardized assessment process conducted periodically to plan resident care) January 21, 2024, revealed that the resident was mildly cognitively impaired, required staff assistance with activities of daily living, including toileting, and was always incontinent of bowel. A review of a care plan dated January 15, 2024 revealed that the resident was at risk for constipation with a goal for the resident to have a normal bowel movement at least every 3 days. Planned interventions were to follow facility bowel protocol for bowel movements and record bowel movement pattern each day. (continued on next page)

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order dated January 15, 2024, was noted for a bowel regimen that included Milk of Magnesia (MOM - a laxative to relieve occasional constipation) 30 ml by mouth every 72 hours as needed for no bowel movement (BM), Dulcolax suppository (Bisacodyl a stimulant laxative) 10 mg, one rectally as needed after MOM is administered and Fleets enema (rectal enema combination medicine used to treat constipation) 7-19 gms, one application rectally as needed after MOM and Dulcolax if no BM, which was the facility's standing bowel protocol. The resident also had an additional current physician order initially dated January 16, 2024, for Polyethylene Glycol 3350 powder 10 gm/15 mg, give 17 gms (mixed in water) by mouth every day (used to treat constipation, a laxative solution that increases the amount of water in the intestinal tract to stimulate bowel movements)for constipation. According to the resident's January 2024 Medication Administration Record (MAR) Resident 1 received the Polyethylene Glycol daily throughout the month of January 2024. A review of Resident 1's bowel movement record revealed that she did not have a bowel movement from January 15, 2024, through January 17, 2024. A review of a January 2024 MAR (medication administration record) revealed that Resident 1 received MOM on January 17, 2024 at 9:30 P.M, which did not produce a bowel movement in response to the medication. Further review of the January 2024 MAR revealed that Resident 1 received a Polyethylene Glycol enema on January 18, 2024 at 12:43 PM. There was no documentation in the clinical record why the resident did not receive the physician ordered bisacodyl suppository as per the facility protocol. In response to the enema, the resident had a large BM at 2 PM on January 18, 2024. A review of a nurses note dated January 18, 2024 at 5:33 PM revealed, at approximately 3:50 PM, Resident 1's daughter called the nursing supervisor to state I want my mother sent to the hospital immediately! She is in excruciating pain! Nursing assessed the resident and noted no pain. The physician assistant was contacted and the PA-C suggested testing the resident in the facility but the resident's daughter insisted on sending her mother to the hospital for evaluation. The resident was sent to the ER at 6 PM. There was no corresponding documented pain assessment or abdominal assessment of the resident, in the resident's clinical as noted in the nurse's note dated January 18, 2024, indicating that the resident was assessed and had no pain, available for the review at the time of the survey ending May 14, 2024. A review of hospital emergency room documentation dated January 18, 2024 at 6:04 P.M. revealed that the resident had complaints of right hip pain, possible multiple falls. The resident was complaining of some abdominal pain and perhaps also some hip pain earlier today according to the ER documentation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A CT (computed tomography scan is a medical imaging technique used to obtain detailed internal images of the body) of the resident's abdomen and pelvis was completed with the following results: bowel: There is marked fecal impaction (Stool can become impacted, or stuck, in your colon, blocking waste from leaving the body. This often causes pain and bloating. Treatment can include laxatives or procedures to remove the stool) with significant distention of the sigmoid colon the sigmoid colon measures approximately 8.3 cm in transverse diameter. The remainder of the colon is decompressed, although limited in evaluation without oral contrast. The resident's stomach is distended. The physician discharge documentation stated was awaiting on discharge patient back to nursing home with a prescription for milk magnesia. However, the resident's daughter called complaining that patient was being sent to nursing home with a fecal impaction seen on CAT scan. Gave patient dose of milk magnesia here in the ER and wait till the morning to wait for the patient to have a bowel movement. Did prescribe patient Milk of Magnesia to take at the nursing home. The resident returned to the facility January 19, 2024 at 6 A.M. A nurses note dated January 19, 2024 at 1:39 P.M. revealed Nursing spoke with the daughter regarding her recent visit to the ER. The daughter is concerned about her mother because the hospital told her the resident had a sever fecal impaction. Reviewed scans from ER visit and it was noted on the CT impression. Daughter stated when her mother was at the hospital in December 2023, she also had a fecal impaction. The nurse practitioner made aware of same. New order received to give a dose of lactulose (a liquid medication sometimes used for constipation) 30 ml now and obtain KUB (abdominal x-ray). Continue the lactulose over the weekend and obtain another KUB on January 22, 2024. A physician order dated January 19, 2024, was noted for the resident to receive Lactulose Oral Solution 10 GM/15 ML, Give 30 ml by mouth once daily for Constipation for 3 Days A review of the January 2024 MAR indicated that Resident 1 received the Lactulose daily from January 19, 2024, through January 11, 2024. There was no evidence at the time of the survey that the hospital recommendation for daily MOM was initiated upon the resident's return to the facility on [DATE]. A repeat mobile X-Ray completed at the facility, KUB X-Ray, dated January 19, 2024 revealed, mild constipation, no bowel obstruction or fecal impaction. There was no documented professional nursing assessment of the resident abdomen prior to the administration of the enema to Resident 1. The facility did not follow the physician ordered bowel protocol (step 2, MOM 30 mls). Further, there was no pain assessment or abdominal assessment completed prior to this residents transfer to the hospital at her daughter's request. There was no nursing documentation as to why the physician prescribed bowel regimen was not implemented after the initial dose of MOM was not effective or the reason the enema was given in lieu of the following the prescribed steps in the protocol. The resident did have a BM after the administration of the enema, but there was no documentation of the status and condition of the resident's abdomen despite her daughter noting the resident's abdominal pain. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview May 14, 2024 at 2 P.M., the Director of Nursing confirmed that the facility failed to administer the physician ordered bowel protocol to the resident during period of time without normal bowel activity and that nursing staff failed to demonstrate a thorough assessment of the resident's abdomen and pain prior to the resident's hospital transfer at family request. 28 Pa Code 211.12 (d)(3)(5) Nursing Services 28 Pa. Code 211.5 (f) Medical records