

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395602	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2025
NAME OF PROVIDER OR SUPPLIER Wesley Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52053</p> <p>Based on clinical record review, select facility policy, and staff interviews, it was determined the facility failed to ensure that residents or their representatives were informed of treatment options, as well as the risks and benefits for psychotropic medications for one of 28 residents (Resident 24).</p> <p>Findings include:</p> <p>A review of a facility policy titled Psychotropic Medication, last reviewed by the facility on March 19, 2025, revealed it is the facility policy that residents shall not receive psychotropic medications which are not clinically indicated to treat a specific condition. Further policy review revealed that documented consent, given voluntarily and free from coercion, by the resident or resident representative (if applicable), to use a psychotropic medication after being provided with sufficient information regarding general psychotropic use and specific considerations related to the psychotropic medication being considered for use will be obtained.</p> <p>A clinical record review revealed that Resident 24 was admitted to the facility on [DATE], with diagnoses that included dementia (irreversible, progressive degenerative disease of the brain, resulting in loss of reality contact and functioning ability) and encephalopathy (dysfunction in brain processes including attention, cognition, and consciousness).</p> <p>A quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) of Resident 24, dated December 28, 2024, revealed the resident was severely cognitively impaired with a BIMS score of 05 (Brief Interview for Mental Status, a tool to assess the residents' attention, orientation, and ability to register and recall new information; a score of 0-7 indicates severe cognitive impairment).</p> <p>Further review of the clinical record revealed that Resident 24 had a designated power of attorney who was their resident representative at the facility.</p> <p>A review of a physician's order dated December 22, 2024, revealed an order for Seroquel 25 milligrams (mg) (an antipsychotic medication used to treat mood disorders) two times a day.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 395602
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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a form titled Psychoactive Medication Informed Consent, dated December 30, 2024, revealed consent for an antipsychotic medication, Seroquel, with a verbal consent checked at the bottom of the form, indicating Resident 24 gave verbal consent. There was no indication that Resident 24's resident representative was made aware of this consent for the antipsychotic medication Seroquel.</p> <p>A review of Resident 24's progress notes revealed no indication that the resident's responsible party were notified of the medication, that the risks and benefits were explained or that the resident was offered alternative treatment options.</p> <p>A review of Medication Administration Records (MARs) from December 2024 to February 2025 for Resident 24 revealed the resident received Seroquel 25 mg twice a day from December 22, 2024, to February 10, 2025.</p> <p>A review of a progress note dated February 10, 2025, revealed the resident representative inquired about discussing Resident 24's medications and was adamant that she did not want her mother to have Seroquel at all and provided a pre-hospital medication list. The physician then re-evaluated and started a gradual dose reduction of Seroquel, and the resident representative was made aware of same.</p> <p>A review of a physician's order dated February 10, 2025, revealed an order for Seroquel 12.5 mg two times a day for 7 days, then 12.5 mg daily for 7 days, then discontinue the medication.</p> <p>The facility was unable to provide the pre-hospital list given by the resident representative on February 10, 2025, and it was not part of the clinical record.</p> <p>Interview with the Nursing Home Administrator (NHA) on May 9, 2025, at 9:00 A.M., confirmed there was no documentation available for review at the time of the survey to indicate that Resident 24's responsible party was informed of the psychotropic medication, that the risks and benefits were explained, or that they were offered alternative treatment options.</p> <p>28 Pa Code 201.29(a) Resident rights</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52053</p> <p>Based on a review of select facility policy, clinical records, and staff interviews, it was determined the facility failed to ensure physician orders were consistent with a resident's documented code status (hospital designation that means to intercede if a patient's heart stops beating or if the patient stops breathing) preference for one of 28 residents reviewed (Resident 75).</p> <p>Findings include:</p> <p>A review of the facility's policy titled Cardiopulmonary Resuscitation, last reviewed on [DATE], indicated that when a resident's resuscitation preference is determined or changed, the facility is responsible for ensuring that the electronic medical record reflects the resident's choice in the Advanced Directives section and that physician orders match the resident's expressed wishes.</p> <p>A review of the clinical record of Resident 75, revealed the resident was admitted to the facility on [DATE], with diagnoses that included hypertension (blood pressure that is higher than normal) and epilepsy (a chronic brain disorder in which groups of nerve cells, or neurons, in the brain sometimes send the wrong signals and cause seizures).</p> <p>A review of Resident 75's clinical record revealed a completed and signed CPR Status form (cardiopulmonary resuscitation- life-saving procedure performed when the heart or breathing stops), dated [DATE], which indicated the resident elected not to receive cardiopulmonary resuscitation (CPR) in the event their heart or breathing stopped.</p> <p>However, further review of the resident's electronic medical record revealed that physician orders entered on [DATE], listed the resident's code status as CPR, meaning resuscitation should be performed. There was no documentation showing that the resident changed their decision or participated in any discussion suggesting an update to their previously signed CPR Status form</p> <p>Following surveyor inquiry, a physician's order was entered on [DATE], to change the code status to DNR (Do Not Resuscitate-a medical order indicating that CPR should not be administered if the resident's heart or breathing stops).</p> <p>An interview with the Nursing Home Administrator (NHA) on [DATE], at 10:00 AM confirmed that physician orders are expected to match the resident's signed CPR Status form. The Administrator acknowledged that the original physician order indicating CPR did not reflect the resident's expressed wishes documented on [DATE], and stated that the inconsistency should have been corrected prior to surveyor identification.</p> <p>28 Pa. Code 201.29(a) Resident rights.</p> <p>28 Pa. Code 211.5 (f)(i) Medical records.</p> <p>28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.</p>		

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<p>F 0628</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</p> <p>Based on review of clinical records, facility-initiated transfer notices, and staff interview, it was determined the facility failed to provide copies of written notice of facility-initiated hospital transfers of residents to a representative of the Office of the State Ombudsman for five out of 28 residents reviewed (Residents 1, 20, 87, 90, and 18).</p> <p>Findings include:</p> <p>A review of the clinical record revealed that Resident 1 was transferred to the hospital on March 8, 2025, and was readmitted to the facility on [DATE].</p> <p>A review of the clinical record revealed that Resident 20 was transferred to the hospital on April 27, 2025, and was readmitted to the facility on [DATE].</p> <p>A review of the clinical record revealed that Resident 87 was transferred to the hospital on March 17, 2025, and was readmitted to the facility on [DATE].</p> <p>A review of the clinical record revealed that Resident 90 was transferred to the hospital on January 10, 2025, and was readmitted to the facility on [DATE].</p> <p>A review of the clinical record revealed that Resident 18 was transferred to the hospital on September 14, 2024, and was readmitted to the facility on [DATE]. Resident 18 was also transferred to the hospital on January 3, 2025, and was readmitted to the facility on [DATE].</p> <p>Although written notices were provided to the resident and resident representative of the facility-initiated transfer, there was no documented evidence the facility sent copies of written notices of these facility-initiated transfers to the representative of the Office of the State Long-Term Care Ombudsman.</p> <p>An interview with the nursing home administrator on May 9, 2025, at approximately 10:00 AM confirmed there was no documented evidence that copies of facility-initiated transfer notices for Residents 1, 18, 20, 87, and 90 were sent to a representative of the Office of the State Long-Term Care Ombudsman. The administrator further confirmed there was no evidence that copies were sent consistently for resident transfers to a representative of the Office of the State Long-Term Care Ombudsman from July 2024 through May 2025.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738</p> <p>Based on clinical record review, review of select facility policy, and staff interview, it was determined the facility failed to provide quality care as evidenced by the facility failure to ensure physician orders were followed for the administration of medication for one resident (Resident 61) and further failed to develop procedures and criteria for a palliative care program (Specialized medical care for people with serious illness. This type of care is focused on providing relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family.) to provide person-centered care in accordance with the comprehensive person-centered care plan, and the residents' choices for palliative care for two of 28 sampled residents (Residents 14 and 39).</p> <p>Findings include:</p> <p>A review of facility policy titled: Preparing, Administering and Documenting Medications last reviewed by the facility on March 19, 2025, indicated that medications are administered within one hour of their prescribed times, unless otherwise specified.</p> <p>Review of Resident 61's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include Parkinson's disease (a progressive disorder that affects movement).</p> <p>A review of the clinical record also revealed a physician's order for Carbidopa-Levodopa (a combination medicine used to treat the symptoms of Parkinson's disease) 50-200 MG, with instructions to administer one tablet by mouth two times a day, was initiated on April 6, 2025.</p> <p>A review of Resident 61's Medication Administration Record for May 2025 revealed that the resident was prescribed and scheduled to receive the following medication: Carbidopa-Levodopa 50-200 milligrams, one tablet by mouth two times a day (8:00 AM and 4:00 PM).</p> <p>A review of the facility's Medication Administration Audit Report for April 6, 2025, through May 6, 2025, revealed the following:</p> <p>April 8, 2025, the medication scheduled for 8:00 AM was not administered until 9:25 AM, 1 hour and 25 minutes after the scheduled time.</p> <p>April 11, 2025, the medication scheduled for 4:00 PM was not administered until 5:30 PM, 1 hour and 30 minutes after the scheduled time.</p> <p>April 13, 2025, the medication scheduled for 8:00 AM was not administered until 9:46 AM, 1 hour and 46 minutes after the scheduled time.</p> <p>April 15, 2025, the medication scheduled for 8:00 AM was not administered until 10:26 AM, 2 hours and 26 minutes after the scheduled time.</p> <p>April 16, 2025, the medication scheduled for 8:00 AM was not administered until 9:12 AM, 1 hour and 12 minutes after the scheduled time.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>April 16, 2025, the medication scheduled for 4:00 PM was not administered until 5:55 PM, 1 hour and 55 minutes after the scheduled time.</p> <p>April 17, 2025, the medication scheduled for 8:00 AM was not administered until 9:35 AM, 1 hour and 35 minutes after the scheduled time.</p> <p>April 18, 2025, the medication scheduled for 8:00 AM was not administered until 11:32 AM, 3 hours and 32 minutes after the scheduled time.</p> <p>April 20, 2025, the medication scheduled for 8:00 AM was not administered until 10:18 AM, 2 hours and 18 minutes after the scheduled time.</p> <p>April 21, 2025, the medication scheduled for 8:00 AM was not administered until 9:33 AM, 1 hour and 33 minutes after the scheduled time.</p> <p>April 23, 2025, the medication scheduled for 8:00 AM was not administered until 9:22 AM, 1 hour and 22 minutes after the scheduled time.</p> <p>May 1, 2025, the medication scheduled for 8:00 AM was not administered until 9:55 AM, 1 hour and 55 minutes after the scheduled time.</p> <p>May 2, 2025, the medication scheduled for 4:00 PM was not administered until 5:57 PM, 1 hour and 57 minutes after the scheduled time.</p> <p>May 3, 2025, the medication scheduled for 8:00 AM was not administered until 9:28 AM, 1 hour and 28 minutes after the scheduled time.</p> <p>May 4, 2025, the medication scheduled for 8:00 AM was not administered until 9:25 AM, 1 hour and 25 minutes after the scheduled time.</p> <p>May 5, 2025, the medication scheduled for 8:00 AM was not administered until 9:22 AM, 1 hour and 22 minutes after the scheduled time.</p> <p>Interview with the Nursing Home Administrator on May 7, 2025, at approximately 10:00 AM confirmed medications should be administered timely in accordance with physician orders and professional standards of practice.</p> <p>Review of the clinical record revealed that Resident 14 was admitted to the facility on [DATE], with diagnoses, which include dementia (group of symptoms affecting intellectual and social abilities severely enough to interfere with daily functioning).</p> <p>A nurses note dated April 22, 2025, indicated the resident representative decided to transition the resident into Palliative Care and orders were placed to reflect the family's request.</p> <p>A physician order dated April 22, 2025, revealed an order for Palliative Care, no weights, oxygen at 2L/min for shortness of breath.</p> <p>A physician order dated April 24, 2025, revealed an order to discontinue by mouth medications.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of the clinical chart for Resident 14 revealed there was no palliative care plan, no signed consent for palliative care, and no doctor or social worker note associated with the palliative care for review.</p> <p>A review of the clinical record revealed that Resident 39 was admitted to the facility on [DATE], with diagnoses that included dementia and atrial fibrillation (a condition that causes the heart to beat irregularly and sometimes much faster than normal).</p> <p>A quarterly Minimum Data Set Assessment (MDS-- a federally mandated standardized assessment conducted at specific intervals to plan resident care) of Resident 39, dated March 20, 2025, revealed the resident was severely cognitively impaired.</p> <p>A review of Resident 39's clinical record revealed that they had a designated power of attorney for care who was their resident representative at the facility.</p> <p>A nursing progress note dated April 17, 2025, documented that facility staff held a discussion with the resident representative regarding the resident's ongoing weight loss. During the conversation, the resident's advance directives were reviewed, and the representative expressed a preference for palliative care, including no feeding tube placement and no hospital transfer.</p> <p>A physician's order dated April 17, 2025, included directives for palliative care, no weights, no parenteral or enteral nutrition or hydration (methods of delivering nutrition via feeding tube or intravenous line), and no laboratory testing. However, the order lacked documentation of a clinical diagnosis or rationale supporting the initiation of palliative care.</p> <p>Further review of the clinical record revealed the absence of a comprehensive palliative care plan, no signed consent from the resident representative authorizing palliative care, and no supporting progress notes from a physician or social worker to document interdisciplinary involvement or justification for the change in the resident's plan of care.</p> <p>An interview conducted with the Director of Nursing and the Administrator on May 9, 2025, at approximately 9:00 AM, failed to produce documentation outlining the clinical rationale or medical necessity for the palliative care orders issued. Additionally, the facility was unable to provide evidence of a facility policy or established criteria used to determine a resident's eligibility for palliative care services.</p> <p>28 Pa. Code 211.10(a)(d) Resident Care Policies</p> <p>28 Pa. Code 211.12(c)(d)(1)(2) 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** 48276</p> <p>Based on a review of clinical records, select facility policy, observation, and resident and staff interviews, it was determined the facility failed to ensure oxygen therapy was administered per physician's orders for one resident out of 28 sampled (Resident 43).</p> <p>Findings include:</p> <p>A review of the facility policy titled Administration of Oxygen, last reviewed by the facility on March 19, 2025, revealed it is the facility's policy to provide oxygen therapy to residents upon order of the physician. The policy indicates it is the responsibility of the licensed nurse to initiate and monitor the administration of oxygen per physician's orders.</p> <p>A clinical record review revealed Resident 43 was admitted to the facility on [DATE], with diagnoses that include chronic respiratory failure with hypoxia (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe).</p> <p>Further clinical record review revealed Resident 43 had an altered respiratory status initiated on February 19, 2025. Interventions implemented to assist Resident 43 with her goal of maintaining a normal breathing pattern included monitoring for signs and symptoms of respiratory distress, reporting to the physician as needed, and providing the resident oxygen via a nasal cannula (a medical device used to deliver supplemental oxygen to a patient through their nostrils) at 1.0 liters per minute (LPM).</p> <p>However, a discrepancy was identified. Resident 43 has a physician's order to receive oxygen at 2.0 liters per minute via a nasal cannula initiated on March 26, 2025.</p> <p>An observation on May 7, 2025, at 12:10 PM revealed Resident 43 was awake and sitting upright in her chair with supplemental oxygen in place via an oxygen concentrator with the liter flow set at 0.0 liters per minute. Tubing connected the oxygen concentrator to her via a nasal cannula. During an interview at the time of the observation, Resident 43 indicated that she couldn't feel any airflow from the nasal cannula.</p> <p>During an interview on May 7, 2025, at 12:15 PM, Employee 2, Licensed Practical Nurse (LPN), confirmed Resident 43 should be receiving continuous oxygen via a nasal cannula at 2.0 liters per minute. Employee 2, LPN, indicated she would set the oxygenator to correctly administer oxygen and check the resident's vital signs.</p> <p>A progress note dated May 7, 2025, at 12:32 PM revealed Resident 43's oxygen concentrator was checked and the liter flow was set to 0.0 LPM. The flow rate was immediately adjusted, and the resident's blood-oxygen saturation (SpO2) was measured with a pulse oximeter (a device that measures the percentage of oxygen carried by red blood cells in the blood, which is referred to as oxygen saturation). The resident's blood-oxygen saturation (SpO2) was 93% (a normal range is 95-100%; however, individuals with chronic diseases may have levels below 95%). Resident denied shortness of breath or distress.</p> <p>(continued on next page)</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>During an interview on May 9, 2025, at approximately 10:00 AM, the Nursing Home Administrator (NHA) confirmed it is the facility's responsibility to ensure oxygen therapy is administered per physician's orders. The NHA also confirmed it is the facility's responsibility to ensure each resident's plan of care is congruent with physician's orders, including orders for oxygen therapy.</p> <p>28 Pa. Code 211.10 (c) Resident care policies.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738</p> <p>Based on clinical record review, select facility policy review, and staff interview, it was determined the facility failed to reassess a resident's pain status and medication prescribed on as-needed (PRN) basis to ensure the development and implementation of an effective, individualized pain management plan for one of 28 residents sampled. (Resident 14).</p> <p>Findings include:</p> <p>A review of the facility's policy for pain assessment and management last reviewed, March 2025, revealed the facility will provide the resident with care and services to address and manage the resident's pain to support his or her highest practicable level of physical, mental, and psychosocial well-being. Using the comprehensive assessment and care plan, current professional standards of practice, and the resident's goals and preferences, the resident will have pain identified and assessed, have the type of pain identified along with appropriate management approaches, and have pain adequately managed (eliminated if possible or relieved to a tolerable level). The policy requires a comprehensive pain assessment upon admission, quarterly, annually, with any significant change in status, and with the onset of new pain.</p> <p>Clinical record review revealed that Resident 14 was admitted to the facility on [DATE], with diagnoses including dementia (group of symptoms affecting intellectual and social abilities severely enough to interfere with daily functioning) and pulmonary hypertension (type of high blood pressure that affects the arteries in the lungs and the right side of the heart).</p> <p>An admission Minimum Data Set assessment (MDS a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated April 13, 2025, revealed a BIMS score (Brief Interview for Mental Status- the BIMS test is used to get a quick snapshot of cognitive function) of 10 (a score of 8-12 indicates moderate impairment), required staff assistance for activities of daily living, no pain the last five days, did not receive scheduled pain medication, and did not exhibit shortness of breath.</p> <p>A physician order initially dated April 11, 2025, noted an order for acetaminophen (pain reliever) 325 mg give two tablets po (by mouth) PRN (as needed) for pain scale of 1-5. Do not exceed 3000 mg/24 hours.</p> <p>A physician order initially dated April 22, 2025, noted an order for oxygen 2L/minute continuous via nasal cannula for shortness of breath.</p> <p>A physician order initially dated April 22, 2025, and discontinued April 28, 2025, noted an order for Morphine Sulfate (narcotic analgesic pain medication) 20 mg/ml give 0.25 mg po every 6 hours PRN for shortness of breath/pain 6-10 for 14 days.</p> <p>A physician order initially dated April 28, 2025, noted an order for Morphine Sulfate 20 mg/ml give 0.25 mg by mouth every 6 hours PRN for shortness of breath for 14 days.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A physician order initially dated May 7, 2025, noted an order for Morphine Sulfate Solution 20 mg/ml give 0.25 ml by mouth every 6 hours PRN for shortness of breath for 14 days with instructions to document respiratory assessment.</p> <p>A care plan-initiated April 9, 2025, identified Resident 14 as at risk for pain and included interventions such as administering acetaminophen as ordered, evaluating effectiveness of pain interventions every shift and as needed. Monitor and report to nurse any signs/symptoms of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out, silence); Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide open/narrow slits/shut, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing).</p> <p>Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain.</p> <p>Despite the established plan, the resident's Medication Administration Record (MAR) revealed the following:</p> <p>April 23, 2025, at 10:07 AM the resident received the PRN Morphine Sulfate based /ml 0.25 mg by mouth for a pain level of 4 (despite prescribed for pain level of 6-10).</p> <p>A review of the resident's May 2025 MAR revealed the PRN Morphine Sulfate 20 mg/ml 0.25 mg for shortness of breath was administered on the following dates:</p> <p>May 1, 2025, at 5:45 PM for a pain level of 4 (no shortness of breath noted)</p> <p>May 3, 2025, at 5:28 AM for a pain level of 7 (no shortness of breath noted)</p> <p>May 3, 2025, at 8:53 PM for a pain level of 5 (no shortness of breath noted)</p> <p>May 4, 2025, at 9:22 PM for a pain level of 4 (no shortness of breath noted)</p> <p>May 6, 2025, at 1:15 AM for a pain level of 5 (no shortness of breath noted)</p> <p>Further review of the clinical record revealed no documented evidence of a comprehensive reassessment of the resident's pain status following the onset of pain on April 22, 2025, nor evidence that the pain management plan was reviewed or modified accordingly.</p> <p>During an interview on May 9, 2025, at approximately 10:00 AM the Director of Nursing (DON) confirmed the following.</p> <p>a comprehensive pain assessment was not completed as per facility policy to help identify Resident 14's cause of pain and develop an individualized pain management program for the resident.</p> <p>Staff administered a narcotic prescribed for pain levels 6-10 when pain levels were consistently documented as 4-5.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395602	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2025
NAME OF PROVIDER OR SUPPLIER Wesley Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>After the April 28, 2025, physician order changed the indication to shortness of breath only, staff continued administering Morphine Sulfate without evidence the resident was experiencing shortness of breath.</p> <p>Staff administered narcotic pain medication on five occasions between May 1, 2025, and May 6, 2025, without a physician order and with no documented evidence the resident was experiencing shortness of breath and there was no evidence of a comprehensive pain reassessment to determine whether the resident's pain management regimen was effective, appropriate, or in need of adjustment.</p> <p>At the time of the survey, there was no documentation that the facility evaluated the cause of Resident 14's pain, reassessed the appropriateness of PRN medications, or modified the care plan to address the resident's emerging symptoms. The facility practice failed to ensure pain management was based on comprehensive reassessment and individual needs.</p> <p>28 Pa. Code 211.5(f)(ix) Medical records</p> <p>28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services</p>		

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NAME OF PROVIDER OR SUPPLIER Wesley Village		STREET ADDRESS, CITY, STATE, ZIP CODE 209 Roberts Road Pittston, PA 18640	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>21738</p> <p>Based on a review of clinical records, observation, and staff interview it was determined the facility failed to provide a physician ordered therapeutic diet (diet ordered by a physician or other delegated provider that is part of the treatment for a disease or clinical condition, to eliminate, decrease, or increase certain substances in the diet, or to provide mechanically altered food when indicated) for one resident out of 28 sampled (Resident 54).</p> <p>Findings include:</p> <p>A review of the clinical record of Resident 54 revealed the resident had diagnoses which included Alzheimer's disease (a progressive brain disorder that causes memory loss, confusion, and other cognitive decline) and oral phase dysphagia (difficulty swallowing which includes problems with using the mouth, lips, and tongue to control food or liquid).</p> <p>Review of a Speech Therapy Treatment Encounter Note dated May 14, 2024, revealed a recommendation for the use of lemon ice to facilitate oral movement for AP transfer [anterior-posterior transfer- the movement of the bolus (food or liquid mass) from the front of the mouth to the back, and then down the throat].</p> <p>A physician order initially dated May 14, 2024, noted an order for a Pureed NAS (no added salt) diet with lemon ice at meals.</p> <p>Observation of the resident's lunch meals on May 6, 2025, at 12:00 PM and May 7, 2025, at 12:10 PM revealed the resident did not receive lemon ice on her meal tray. Review of the resident's meal tray ticket revealed no written order for lemon ice with meals.</p> <p>Interview with employee 1 (LPN) on May 7, 2025, at approximately 12:10 PM confirmed that lemon ice was not designated on the resident's meal tray ticket.</p> <p>During an interview on May 9, 2025, at approximately 9:30 AM the Certified Dietary Manager (CDM) confirmed that Resident 54's current physician orders included lemon ice with each meal. The CDM confirmed the facility failed to provide lemon ice on the resident's meal trays to facilitate swallowing.</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services</p>		

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NAME OF PROVIDER OR SUPPLIER Wesley Village		STREET ADDRESS, CITY, STATE, ZIP CODE 209 Roberts Road Pittston, PA 18640	
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<p>F 0848</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide a neutral and fair arbitration process and agree to arbitrator and venue.</p> <p>48276</p> <p>Based on review of the facility's admission agreement and staff interview, it was determined that the facility failed to ensure a neutral and fair arbitration process by ensuring both the resident and resident representative, and the facility agree on the selection of a venue that is convenient to both parties.</p> <p>Findings include:</p> <p>A review of the facility's Admission Agreement packet, specifically Section 19.4 Binding Arbitration Subsection (f) Location of Arbitration, contained Subject to mutual agreement of the parties, the arbitration will be conducted at the facility or at a site within a reasonable distance of the facility.</p> <p>During an interview on May 9, 2025, at approximately 10:30 AM, the Nursing Home Administrator (NHA) confirmed the language of the arbitration agreement does not state that the location of the arbitration will be at a venue that is convenient to both the resident/resident representative and the facility. The NHA confirmed the language of the policy states two options for the location of arbitration (1) at the facility or (2) a site within a reasonable distance of the facility.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p> <p>28 Pa. Code 201.29(a) Resident rights.</p>		