

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395685	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/05/2025
NAME OF PROVIDER OR SUPPLIER Wallingford Skilled Nursing and Rehabilitation Cen		STREET ADDRESS, CITY, STATE, ZIP CODE 115 South Providence Road Wallingford, PA 19086	

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 0585</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 voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>Based on review of facility documents and staff interviews it was determined that the facility failed to document grievance resolutions for four of six residents (Resident R4, R5, R6, and R7). Findings include: Review of the facility policy Grievances/Concern dated 1/8/25, stated The Administrator will serve as the Grievance Officer who is responsible for overseeing the grievance process, including Civil Rights grievances/concerns, receiving and tracking grievances through to their conclusion, leading any necessary investigations by the facility, maintaining the confidentiality of all information associated with grievances, for example, the identity of the patient for those grievances submitted anonymously, issuing written grievance decisions to the patient. Review of facility grievance forms revealed that the form section titled Resolution of Grievance/Concern included areas to document the following: If the grievance was resolved. Date of resolution. Date that written resolution was provided, if necessary. Method used to notify resident or representative of grievance resolution, if not written. Signature and title of staff member resolving the grievance. Signature and title of the grievance officer. Review of a grievance filed on 5/13/25, on behalf of Residents R4 and R5, failed to include documentation including if the grievance was resolved, the date of the resolution, and notification to resident or representative of the resolution. Review of a grievance filed on 5/25/25, on behalf of Resident R6, failed to include documentation of what staff member received the grievance and the resolution date. Review of a grievance filed on 6/23/25, on behalf of Resident R7, revealed the section titled, Resolution of Grievance/Concern to be blank. During an interview on 8/5/25, at approximately 12:00 p.m., the Director of Nursing and the Administrator in Training confirmed the facility failed to institute corrective actions and resolve resident grievances for four of six residents. 28 PA. Code:201.18(b)(2) Management. 28 PA. Code:201.29(a) Resident's Rights.</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 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** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to protect residents from abuse for one of six residents (Resident R10). Review of the facility policy, Abuse Prohibition dated 5/21/25, defined verbal abuse as any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to patients or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include but are not limited to: threats of harm; saying things to frighten a patient, such as telling a patient that they will never be able to see their family again. Review of the clinical record indicated Resident R10 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized speech and behavior), autism disorder, and excoriation (skin-picking) disorder. Review of Section C indicated a BIMS score of 12 (8-12 moderate cognitive impairment, 13-15 cognitively intact). Review of a grievance filed by Resident R10 dated 7/2/25, indicated Resident R10 reported to Social Worker Employee E10 that he was verbally abused by Registered Nurse (RN) Employee E11. Review of statement written by Social Worker Employee E10 indicated, At 1630 (4:30 p.m.) EDT (Eastern Daylight Time) 7/2/25, resident asked to see undersigned. In mtg. (meeting), resident tearful. Resident stated: 'Today when [RN Employee E11] was doing treatment on my back, I guess I may have scratched it again, but she was very mean to me. She started yelling at me, and she said to me' You better stop picking at your wounds or you will never go back home. I have another care meeting next Friday July 11th with the group home staff. I'm afraid [RN Employee E11] is going to say or do something and I will never be able to go back home. She was so mean to me. She was so mad at me.' Review of an employee statement dated 7/2/25, written by RN Employee E11, indicated, [Resident R10] has a large trauma wound on his left shoulder/back. He has increased his picking causing his wound to have extreme delay in healing. On this day [Resident R10's] dressing was removed by him x2 and he picked his wound and caused moderate bleeding and removing tissue from the wound. I have educated him several times that his picking can cause the wound to become infected and delay his discharge. I had to replace his dressing for the third time on 7/2/25 and I did raise my voice to the resident and tell him he needed to stop picking at his wound and that his group home will not take him back until his wound is healed and they do not give that level of care. Resident was seen by psych and his trazodone has now been increased to TID (three times daily). Review of supporting documents attached to the grievance indicated that Resident R10 was interviewed on 7/8/25, at 12:02 p.m., and confirmed that RN Employee E11 yelled at him about picking his wound. He still feels that she will do or say something so he can't go back home. He prefers not to have to deal with her. During an interview on 8/5/25/25, at approximately 12:00 p.m., the Director of Nursing (DON) and the Administrator in Training confirmed that that RN Employee E11 spoke negatively to Resident R10 about a symptom of a diagnosed medical condition, and confirmed that RN Employee E11 raising her voice and verbalizing what was perceived to Resident R10 as a threat to not be able to return to his group home constituted verbal abuse. The DON further confirmed that the facility failed to implement policies and procedures to protect residents from abuse for one of six residents. 28 Pa. Code 201.14(a)(c)(e) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) (e)(1) Management.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of state laws, facility policies, clinical records, and staff interviews, it was determined that the facility failed to implement policies and procedures to report allegations of neglect for failing to implement policies and procedures to report allegations of abuse and/or neglect for six of ten residents (Resident R4, R5, R7, R8, R9, and R10). Findings include: Review of the Older Adult Protective Services Act of 11/6/87, amended by Act 1997-13, Chapter 7, Section 701, requires any employee or administrator of a facility who suspects abuse is mandated to report the abuse. All reports of abuse should be reported to the local area agency on aging and licensing agencies. Review of the facility policy, Abuse Prohibition dated 5/21/25, indicated that immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the facility will perform the following. -Report allegations to the appropriate state and local authority(s) involving neglect, exploitation or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of patient property not later than two (2) hours after the allegation is made if the event results in serious bodily injury.-Report allegations to the appropriate state and local authority(s) involving neglect, exploitation or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of patient property within 24 hours if the event does not result in serious bodily injury. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2024, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact8-12: moderately impaired0-7: severe impairment Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 5/4/25, included diagnoses of respiratory failure with hypoxia (condition where the body doesn't have enough oxygen in the tissues) and heart failure (a progressive heart disease that affects pumping action of the heart muscles). Review of Section C indicated a BIMS score of 10. Review of Section H: Bladder and Bowel indicated Resident R4 was always incontinent of bladder and bowel. Review of the clinical record indicated Resident R5 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of polyneuropathy (condition where multiple nerves are damaged, causing pain, decreased sensation, and weakness) and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Section C indicated a BIMS score of 04. Review of Section H: Bladder and Bowel indicated Resident R5 was frequently incontinent of bladder and bowel. Review of the clinical record indicated Resident R8 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of dementia and history of a stroke. Review of Section C indicated a BIMS score of 03. Review of Section H: Bladder and Bowel indicated Resident R8 was frequently incontinent of bladder and bowel. Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of dementia and muscle weakness. Review of Section C indicated a BIMS score of 05. Review of Section H: Bladder and Bowel indicated Resident R9 was frequently incontinent of bladder and always incontinent of bowel. Review of a staff-submitted grievance filed on Resident R4 and R5's behalf dated 5/13/25, indicated When I came in the morning, did my rounds, I noticed [Resident R4 and R5's] brief soaked. I told 11-7 (11:00 p.m. - 7:00 a.m.) assigned CNA (nurse aide) but she stated she just changed them and she is about to leave. Then when 7-3 (7:00 a.m. - 3:00 p.m.) CNA came in they also reported that [Resident R8 and R9] were soaked as well and still in their previous clothes. Review of reports submitted to the local state field office did not include a report of allegations of neglect for Residents R4, R5, R8, and R9. Review of the clinical record indicated Resident R7 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of amyotrophic lateral sclerosis (ALS, a progressive neurological disorder which results in weakened muscles and deformity) and neurogenic bladder (bladder problems due to disease or injury of the nervous system involved in the control of urination). Review of Section C indicated a BIMS score of 15. Review of a grievance filed on Resident R7's behalf dated 6/23/25, indicated Resident R7 was crying because her nurse would not provide her as needed medications: Zofran (medication for nausea, Gas-x (medication to treat excess digestive gas) and Flexeril (medication used to treat muscle spasms and pain). Additionally, the grievance stated, Come on man, I don't have time for this. If you are going to keep asking about your medication, I am (missing information). Review of reports submitted to the local state field office did not include a report of allegations of neglect or verbal</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of state laws, facility policies, clinical records, and staff interviews, it was determined that the facility failed to fully investigate allegations of neglect for four of six residents (Resident R4, R5, R8, and R9). Findings include: Review of the facility policy, Abuse Prohibition dated 5/21/25, defined indicated the facility will Initiate an investigation within 24 hours of an allegation of abuse that focuses on:- whether abuse or neglect occurred and to what extent;- clinical examination for signs of injuries, if indicated;- causative factors; and- interventions to prevent further injury. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2024, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact8-12: moderately impaired0-7: severe impairment Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 5/4/25, included diagnoses of respiratory failure with hypoxia (condition where the body doesn't have enough oxygen in the tissues) and heart failure (a progressive heart disease that affects pumping action of the heart muscles). Review of Section C indicated a BIMS score of 10. Review of Section H: Bladder and Bowel indicated Resident R4 was always incontinent of bladder and bowel. Review of the clinical record indicated Resident R5 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of polyneuropathy (condition where multiple nerves are damaged, causing pain, decreased sensation, and weakness) and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Section C indicated a BIMS score of 04. Review of Section H: Bladder and Bowel indicated Resident R5 was frequently incontinent of bladder and bowel. Review of the clinical record indicated Resident R8 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of dementia and history of a stroke. Review of Section C indicated a BIMS score of 03. Review of Section H: Bladder and Bowel indicated Resident R8 was frequently incontinent of bladder and bowel. Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of dementia and muscle weakness. Review of Section C indicated a BIMS score of 05. Review of Section H: Bladder and Bowel indicated Resident R9 was frequently incontinent of bladder and always incontinent of bowel. Review of a staff-submitted grievance filed on Resident R4 and R5's behalf dated 5/13/25, indicated When I came in the morning, did my rounds, I noticed [Resident R4 and R5's] brief soaked. I told 11-7 (11:00 p.m. - 7:00 a.m.) assigned CNA (nurse aide) but she stated she just changed them and she is about to leave. Then when 7-3 (7:00 a.m. - 3:00 p.m.) CNA came in they also reported that [Resident R8 and R9] were soaked as well and still in their previous clothes. Review of the resolution of the grievance indicated that the nurse aide who was alleged not to have provided care was from a nursing agency and would not be allowed to return to the facility for work. The facility was unable to provide an investigation into an allegation of neglect based on the above grievance. During an interview on 8/5/25, at approximately 12:00 p.m., the Director of Nursing (DON) and the Administrator in Training (AIT) confirmed that that an investigation was not completed to ascertain if the licensed nurse supervising the above nurse aide had concerns about her job performance, if other residents on the above nurse aides assignment were provided care, nor was their documentation that skin checks were completed to ensure no skin injuries were incurred due to Residents R4, R5, R8, and R9's extended time left in soiled briefs/clothing. The DON and AIT further confirmed that the facility failed to fully investigate allegations of neglect for four of six residents. 28 Pa. Code 201.14(a)(c)(e) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) (e)(1) Management.</p>		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, observations, and staff interviews, it was determined that the facility failed to make sure that medical supplies and medications were properly stored and/or disposed of in two of two medication rooms (Two South and Two North) and two of four medication carts (Two South Long Hall and Two South Short Hall). Review the facility policy, Storage of Medications dated, indicated, Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to keep their integrity and to support safe, effective drug administration. Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy, if a current order exists. Review of the U.S. FDA approved prescribing information for Lantus (a type of insulin, an injectable medication to treat diabetes) dated 05/2019, indicated that in-use injection pens must be used within 28 days. Review of the U.S. FDA approved prescribing information for insulin lispro (a type of insulin) dated 05/2015, indicated that in-use injection pens must be used within 28 days. During an observation of the Two South nursing unit medication room on [DATE], at approximately 3:30 p.m., the following was observed: (1) Debridement tray [DATE].(1) Package oxygen tubing, [DATE](3) Safety needles, 03/2019.(1) Extension tubing with connector [DATE].(5) Transport swabs [DATE].(3) Urinary catheter securement devices 02/2020.(4) Urinary catheter securement devices [DATE].(1) Urinary catheter securement device [DATE].(1) Urinary catheter securement device [DATE].(1) Urinary catheter [DATE].(1) Urinary catheter [DATE].(2) Urinary catheter insertion kits [DATE].(1) Pair sterile gloves [DATE].(6) Pair sterile gloves 07/2024.(1) Needleless connector [DATE].(1) Luer access device [DATE].(2) Dressing change trays [DATE].(1) Dressing change tray [DATE].(6) Pair sterile gloves 07/2024.(1) Bottle ostomy lubricating deodorant 05/2024. During an interview on [DATE], at approximately 4:00 p.m., the DON and Registered Nurse (RN) Employee E1 confirmed the above medical supplies were expired. During an observation of the Two North nursing unit medication room on [DATE] at approximately 5:20 p.m., the following was observed: (6) Luer lock access devices [DATE](1) Package oxygen tubing, [DATE](5) Safety needles, 09/2018(1) Transfer straw kit 09/2020(1) Tuberculin syringe [DATE](1) IV catheter 04/2009(1) Syringe with connector [DATE].(5) Blood collection needles [DATE].(1) Tissue infusion sets [DATE].(1) Tissue infusion sets [DATE].(1) Dressing change tray [DATE].(1) Luer access device 08/2017.(1) Luer access device [DATE].(2) 2023-2024 season Fluzone High Dose influenza vaccines.(1) Vial tuberculin solution (Tubersol) with an open date of 12/2(3) Transdermal scopolamine patches Feb/25. During an interview on [DATE], at 5:35 p.m., Licensed Practical Nurse (LPN) Employee E2 confirmed the above medications and medical supplies were expired. During an observation of the Two South Long Hall medication cart on [DATE], at 5:45 p.m., the following was observed:One partially used Lantus injection pen with a written open date of [DATE], and a written expiration date of [DATE]. One partially used Lantus injection pen, undated. One partially used lispro injection pen, with [DATE], written on the pen lid, and [DATE], written on the dating sticker. During an interview on [DATE], at 5:48 p.m. LPN Employee E3 confirmed the above injection pens were undated and/or expired. During an observation of the Two South Short Hall medication cart on [DATE], at 5:50 p.m., the following was observed:Two partially used Lantus injection pens, undated. During an interview on [DATE], at 5:53 p.m., RN Employee E4 confirmed the above injection pens were undated. During an interview on [DATE], at approximate 12:00 p.m., the DON and the Administrator in Training confirmed that the facility failed to make sure that medical supplies and medications were properly stored and/or disposed of in two of two medication rooms. 28 Pa. Code: 201.14 (a) Responsibility of licensee.28 Pa. Code: 201.18 (b)(1)(e)(1) Management.28 Pa. Code: 211.9 (a)(1) Pharmacy services.28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services.</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>(continued on next page)</p>

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical record review, and staff interviews, it was determined that the facility failed to obtain the required dental services for three of five residents. (Resident R1, R2, and R3) Findings include: Review of the facility policy, titled Dental Services dated May 21, 2025, revealed the facility will provide, or obtain from an outside resource, routine and emergency dental services to meet the needs of each patient. Review of the clinical record indicated that Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated June 4, 2025, included diagnoses of Anemia (too little iron in the body causing fatigue) and Dementia (group of symptoms that affects memory, thinking and interferes with daily life). Review of Section L: Oral/Dental Status revealed Resident R1 had experienced, Mouth or facial pain, discomfort or difficulty with chewing within the lookback period (5/28/25 through 6/4/25). Review of Resident R1's plan of care failed to reveal goals and interventions related to dental services or mouth pain until June 2, 2025. Review of a nurse practitioner progress note created on April 15, 2025, at 7:18 p.m., indicated She is being seen today at [resident] request due to complaint of tooth pain. Upon exam, no obvious tooth abnormality or deformity noted, but patient reports pain in right upper back tooth. No increased redness or edema noted. [Resident] denies any other pain or discomfort at this time. The progress further noted: Assessment & Plan:#Tooth pain-acute-new order given to consult dentist.-new order given for Tylenol (acetaminophen, non-narcotic pain medication) 650 mg PO TID (by mouth, three times daily) x5 days. Review of Resident R1's physician note dated April 21, 2025, at 1:03 p.m., revealed Resident R1 C/o (complains of) tooth pain which [he/she] has 2 weeks, relieved by Tylenol. No abscess seen. Dental to see at facility. The progress further noted: Plan:*Tooth Pain-Dental referral placed-d/w (discussed with nursing-Tylenol for pain prn (as needed). Review of a nurse practitioner progress note dated May 27, 2025, at 3:34 p.m., revealed, No dental consult completed, order placed on 4/21, d/w nursing to schedule. The progress further noted:*Tooth Pain--still pending consult---Dental referral placed-d/w nursing.-Tylenol for pain prn, Review of a change in condition progress note dated June 2, 2025, at 3:30 pm., revealed Resident R1 was experiencing pain and required a dental consult related to pain and tooth cracked. Review of a nurse practitioner progress note dated June 2, 2025, at 3:26 p.m., revealed Resident R1 was seen related to a toothache. Pt (patient) is reporting severe pain L (left) upper side of mouth. On exam, there are no abscesses noted. R (right) upper quadrant tooth 5 or 6 appears chipped/cracked. The progress further noted:#Toothache, acute, labile-Pt c/o R upper quadrant toothache-Order APAP (acetaminophen) 1 gm q 8 x 7 days then PRN (1 gram every 8 hours for seven days, then as needed).-Order Anbesol (topical anesthetic that numbs the skin or mouth for pain relief) qid (four times daily) as prn.-Refer to dentist. Review of Resident R1's progress note dated June 10, 2025, at 4:36 p. m., revealed Resident R1 returned from his/her dental appointment, with temporarily Bridge 2-3-4-5 that is broken in 2 places. Recommendation: needs permanent bridge 2 thru 5. New order Amoxicillin (antibiotic medication). Review of a follow-up note dated June 11, 2025, at 2:08 p.m., revealed Pt initially referred to dentist for L[eft] sided toothache. Reviewed paperwork from appt. Pt with broken temporary bridge 2-5. Recommendations to f/u for permanent bridge as well as course of Amoxicillin. Pt examined today post visit. [Resident] reports [he/she] continues to have pain in L upper quadrant of mouth thought it has improved with APAP. Review of Resident R1's progress note dated June 18, 2025, at 3:06 p.m., revealed Resident R1 was transferred to the hospital for tooth pain/swollen jaw. Review of Resident R1's nurse practitioner progress note dated June 18, 2025, at 3:59 p.m., revealed Pt seen today by request of unit manager for evaluation of swollen face and pt crying in pain. Pt was examined while sitting up in chair. Pt is in obvious distress. [Resident] is crying reporting pain in [his/her] mouth. [Resident] is unable to provide further details only repeating [he/she] needs to see a doctor. On exam, pt with flat red, blotchy area on skin from chin on R side of face. Upper and bottom lips are swollen. Unable to examine inside of pt's mouth as [he/she] is unable to open mouth wide enough presumably due to pain. Review of hospital documentation dated June 18, 2025, revealed Resident R1 was treated in the emergency room for dental pain and a dental infection. Review of Resident R1's progress note dated June 19, 2025, at 2:38 a.m., indicated Resident returned to the facility at 0230 (2:30 a.m.). N/O (new order) to start Augmentin (antibiotic medication) and to schedule a dental appointment ASAP (As Soon As Possible). Review of a follow-up progress note dated June 19, 2025, at 6:31 n m. revealed Pt seen today for f/u (follow up) of facial swelling and tooth pain. Pt transferred to ED</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395685	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/05/2025
NAME OF PROVIDER OR SUPPLIER Wallingford Skilled Nursing and Rehabilitation Cen		STREET ADDRESS, CITY, STATE, ZIP CODE 115 South Providence Road Wallingford, PA 19086	
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on a review of facility documents, policy review, observations, and staff interviews, it was determined that the facility failed to properly restrain hair and failed to properly store food items to prevent possible cross-contamination in the Main Kitchen. Findings include: Review of the facility dietary policy, Personal Hygiene dated 5/1/25, indicated Hair restraints such as hats, hair coverings, or nets are worn to effectively keep hair from contacting exposed food. Facial hair coverings are used to cover all facial hair. Review of the facility policy, Refrigerated/Frozen Storage dated 5/21/25, indicated that food stored under refrigeration/freezer storage is maintained in a safe and sanitary manner. All foods are labeled with the name of product and the date received and use by date once opened. Prepared foods are labeled and dated with the name of the product, date opened, and use by date. During an observation of the Main kitchen on 7/31/25, at approximately 4:05 p.m., the following was observed: Dietary Employee E5 admitted the surveyor to the kitchen. When the surveyor retrieved a hairnet immediately upon entering the kitchen and stepped to the hall to place it on, Dietary Employee E5 retrieved a hairnet and placed it on. Observation of the food preparation area revealed both the industrial food mixer and the slicing machine to be uncovered. In the main cooler:-One package of deli meat, wrapped in plastic wrap, without a date.-Six packages of sliced or shredded cheese, wrapped in plastic wrap, without a date.-One package of unknown meat strips, wrapped in plastic wrap, without a date.-One pan of gray-colored pureed food, not dated.-One package of butter, partially used, with the paper wrapping folded back over it, not dated. -One large pan of three uncut meat roasts, wrapped in foil, not dated.-One pan of yellowed pureed food, not dated. -One plastic container of premade omelets, covered with plastic wrap, not dated. -One plastic jug of white beans, without an open date, with a preprinted use-by date of 7/12/25. -Five packages of tubes of unsliced deli meat, wrapped in plastic wrap, not dated. -Two unopened packages of bologna, with a preprinted use-by date of 7/19/25. -Three packages of partially sliced ham, wrapped in plastic wrap, not dated.-A large pan of red gelatin, with a sticker on it that indicated it was made on 7/23/25, and was to be used by 7/27/25.-The fan located at the ceiling was observed to be leaking condensed water onto the bags of potatoes and multiple boxes of food items. In the freezer:-One open box of fish filets, with the inside plastic liner opened, exposing the food to air, not dated.-A Styrofoam cup with a personal drink on the shelf.-Boxes of food items stacked directly on the floor of the freezer. During an observation on 7/31/25, at 4:22 p.m., Dietary Employee E6 was observed to have a beard, without a facial covering over it. Dietary Employee E6 confirmed that the beard nets were locked in the Dietary Manager's office. During an interview on 7/31/25, at 4:25 p.m., the Administrator in Training confirmed the observation of open, undated foods, the presence of expired foods, the mixer and the slider not being covered, the compressor fan in the cooler leaking water onto food items, and two of three dietary staff present not wearing hair and/or beard restraints. During an interview on 8/4/25, at 12:00 p.m., the Director of Nursing and the Administrator in Training confirmed the facility failed to properly restrain hair and failed to properly store food items to prevent possible cross-contamination in the Main Kitchen. 28 Pa. Code: 211.6(c) Dietary services.</p>		

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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 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>Findings include: Review the facility policy, Storage of Medications dated, indicated, Medications should be stored so that various routes of administration are separated. Internally administered medications are stored separately from medications used extermally such as lotions, creams, ointments, and suppositories. During an observation on 7/31/25, at approximately 5:37 p.m., the treatment cart stored in the Two North Medication room was observed. Upon opening the top drawer, it was noted that the treatment supplies were placed haphazardly in the drawer, with no separation of medications/biologicals based on resident or route of administration. A partial list of what was noted in the cart:Santyl ointmentsCollagenase ointmentsZinc oxide paste.Voltaren cream.Multiple types of gauze and dressing suppliesWound measuring tools.Anti-dandruff shampoo.Medi-honey.Antifungal sprays.Prescription antifungal powder.Multiple rolls of tape.Iodosorb.Vashe wound cleanser.A non-functional thermometer.A watch. Disposable shavers. Upon opening the second drawer, it was noted that the treatment supplies were placed haphazardly in the drawer, with no separation of medications/biologicals based on resident or route of administration. A partial list of what was noted in the cart:Santyl ointmentsZinc oxide paste.Voltaren cream.Multiple types of gauze and dressing suppliesAquafor. Anti-dandruff shampoo.Facial tissue.Antifungal cream.Bandages.Body cleansing wipes.Multiple rolls of tape. Dakin's Solution.Wound cleanser. During an interview on 7/31/25, at approximately 5:40 p.m., Licensed Practical Nurse Employee E2 confirmed the treatment cart was actively in use daily, confirmed the above observations, and confirmed that not storing medications and biologicals for different residents created the potential for cross-contamination between residents. During an interview on 8/5/25, at approximately 12:00 p. m., the Director of Nursing and the Administrator in Training confirmed the facility failed to maintain infection control practices during medication storage for one of two treatment carts. 28 Pa Code: 201.14 (a) Responsibility of licensee.28 Pa Code: 201.28 (b)(1)(e)(1) Management. 28 Pa Code: 211.10 (d) Resident care policies.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>Based on facility policy, observations, resident and staff interviews, and review of pest control documentation it was determined that the facility failed to maintain an effective pest control program on two of four nursing units (One North and Two South nursing units). Findings include: Review of the facility preventive maintenance policy, Infection Control Practices dated 5/21/25, indicated the facility will provide a pest free environment. During an interview on 7/31/25, at approximately at approximately 1:30 p.m., the Nursing Home Administrator confirmed that there had been a bat in the facility, but it had been disposed of by staff. During an interview on 8/1/25, at approximately 11:54 a.m., Resident R11 stated that she had seen mice in her room. During an observation on 8/1/25, at approximately 11:58 a.m., of Resident R12, R13, and R14's room, fruit flies were observed. During an interview on 8/1/25, at approximately 12:00 p.m., Resident R18 stated that he has seen mice in his room. During an interview on 8/1/25, at approximately 12:04 p.m., Resident R16 stated that she has seen field mice in her room. During an interview on 8/1/25, at approximately 12:10 p.m., Resident R17 stated that he has often seen field mice. Resident R17 was interviewed in the unit dining room. Resident R17 gestured to the PTAC unit (packaged terminal air conditioner, a type of self-contained heating and air conditioning system) and stated that there was a hole there, and the mice would come in. Resident R17 also stated that he has seen mice run from beneath the soda machine. During an interview on 8/1/25, at approximately 12:15 p.m., Resident R14 stated that he saw a mouse yesterday (7/31/25). During an interview on 8/1/25, at approximately 12:20 p.m., when asked if he has seen mice in the facility, Resident R15 Sure, all the time. This whole place is full of mice. I had two in my room. During an interview on 8/5/25, at approximately 12:00 p.m., the Director of Nursing and the Administrator in Training confirmed that the facility failed to maintain an effective pest control program on two of four nursing units. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 207.2 Administrator's responsibility.</p>		