STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395685	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wallingford Skilled Nursing and Rehabilitation Cen	115 South Providence Road Wallingford, PA 19086

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 41765 Based on a review of the facility's policy, clinical records review, and staff interview, it was determined that the facility failed to notify the physician of a significant weight change for one of the 35 residents reviewed (Resident 114). Findings include: A review of the facility's policy titled Weights and Heights, last revised on February 1, 2023, revealed, that if the body weight is not expected, re-weigh the patient. A significant weight change is defined as 5% in one month and 10% in six months. Significant weight changes will be reviewed by the licensed nurse for assessment. The physician and Dietitian will be notified, and notification of the physician and Dietitian will be documented in the Weight Change Progress Note. Clinical records review revealed Resident 114 had a diagnosis of Congestive Heart Failure (CHF weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs). A review of Resident 114's weights and vitals revealed a weight of 131.2 pounds on November 4, 2024, and 150.2 pounds on December 5, 2024, a 19 pounds (14.48%) significant weight gain in one month. The clinical records review failed to reveal that the resident was assessed and that the physician was notified of the significant weight change identified on December 5, 2024. Clinical records review revealed Resident 114's weight was not rechecked until December 11, 2024, six days after significant change was identified with a weight result of 154.2 pounds. December 11, 2024, clinical records review failed to reveal that the physician was notified of the significant weight change. An interview with licensed nurse Employee E9 conducted on December 12, 2024, at 11:30 a.m., confirmed that the physician was not notified of Resident 114's significant weight change. The facility failed to ensure physician was notified of Resident 114's significant weight change. 28 Pa Code: 211.10(c) Resident care policies (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services

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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. 37789 Based on clinical record review and employee interview it was determined that the facility failed to ensure physician's orders were followed for one of 35 residents reviewed (Resident 19). Findings include: Review of Resident 19's physician's orders revealed an order dated October 3, 2023, for oxygen 2 liters via nasal cannula (tubing that wraps around the ears that supplies oxygen via the nose). Further review of Resident 19's physician's orders revealed an order dated March 7, 2024, to maintain ear protectors on oxygen tubing at all times. Review of Resident 19's Treatment Administration Records revealed staff were signing off that the ear protectors were maintained on the oxygen tubing. Review of Resident 19's progress notes revealed a practitioner note dated August 28, 2024, which stated: this is [an acute] visit per nurse request. Patient has [significant] redness and swelling behind left ear. Patient has oxygen and per nurse she injures area with oxygen tubing. The practitioner prescribed doxycycline (antibiotic) 100 milligrams twice daily for seven days, hydrocortisone cream to the left ear twice daily for 10 days, and Bactroban (antibiotic ointment) to the left ear for 10 days. Further review of Resident 19's progress notes revealed a nurse's note dated August 28, 2024, which stated: Skin note: abrasion to behind left ear caused by nasal cannula without oxyears [(protection on the oxygen tubing to prevent skin breakdown to the ears)]. Further review of Resident 19's progress notes revealed a practitioner note on September 19, 2024, which stated that the area to the resident's left ear resolved. The facility's failure to maintain ear protectors on Resident 19's oxygen tubing was discussed with and confirmed with the Nursing Home Administrator on December 12, 2024, at 9:50 a.m. 28 Pa. Code 201.18(b)(1) Management 28 Pa. 211.12(d)(1)(3)(5) Nursing services 28 Pa. Code 211.5(f) Clinical records

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765 Based on observation, clinical records review, and staff interview, it was determined that the facility failed to ensure adequate assistance was provided to prevent a fall for one of the 35 residents reviewed (Resident 156). Findings include: A review of Resident 156's diagnosis list includes cerebral infarction (a condition that occurs when blood flow to the brain is blocked, resulting in brain tissue death), contracture (a permanent tightening of the muscles, tendons, and ligaments that prevents normal movement of a joint or body part), falls, and intellectual disabilities. A review of the Quarterly Minimum Data Set (MDS- A standardized assessment tool that measures health status in long-term care residents) dated November 8, 2025, revealed Resident 156 had a moderate cognitive impairment. The same MDS revealed that the resident had impairment to one side of the upper and lower extremities. The resident was dependent on toileting and personal hygiene. State MDS dated [DATE], revealed that the resident required extensive assistance with two-person help with bed mobility. An observation conducted on December 9, 2024, at 10:00 a.m., revealed the resident lying in bed with left hand /wrist bent inward and left knees bent. A review of the Occupational Therapy (OT-A professional staff that assists people in regaining their physical and psychological well-being) evaluation report dated November 6, 2024, revealed that functional Skills Assessment with toileting and dressing on the lower body revealed resident was dependent with two or more helpers. A review of the nursing progress notes dated November 27, 2024, at 2:25 a.m., revealed Resident was observed in a side-lying position (on the floor), the caregiver stated that she/he turned the resident onto his/her side and lunged off the edge of the bed. The resident was assessed with no visible sign of pain. A review of the facility's investigation revealed that on November 27, 2024, the resident was observed lying on his left side on the bedroom floor, with his face towards the bed. The resident was unable to give an account of the incident. A review of the statement completed by unlicensed staff Employee E10 on November 27, 2024, revealed While doing care on the resident, he/she suddenly lunges to the side of the bed and landed on the floor, I called out for help. An interview with the Nursing Home Administrator, conducted on December 12, 2024, at 10:30 a.m., confirmed that during the fall, there was only one staff providing care to the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure adequate supervision of two staff memebers was provided to Resident 156 while care was being provided resulting in a fall. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 37789 Based on review of facility procedure, observation, and clinical record review, it was determined that the facility failed to provide documented evidence that consistent, adequate catheter care was provided to one of five residents reviewed for catheters (Resident 167). Findings include: Review of facility procedure, Catheter: Indwelling Urinary - Care of, last revised February 1, 2023, revealed that catheter care is to be performed twice daily and as needed, and the catheter care is to be documented in the clinical record. Observation of Resident 167 on December 10, 2024, at approximately 9:00 a.m. revealed the resident had a Foley catheter (a thin, flexible tube placed in the bladder through the urethra to drain urine). Review of Resident 167's physician's orders, Medication Administrator Records, Treatment Administration Record, and care plan failed to reveal evidence that the resident was receiving routine catheter care. The above findings were discussed and confirmed with the Nursing Home Administrator on December 12, 2024, at approximately 9:50 a.m. 28 Pa Code 211.12(d)(5) Nursing Services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 37789 Based on review of facility procedure and clinical record review, it was determined that the facility failed to adequately monitor and address significant weight loss in one of nine residents reviewed for nutrition (Resident 130). Findings include: Review of facility procedure Weights and Heights, last revised February 1, 2023, revealed: If the body weight is not as expected, re-weigh the patient. The policy further stated: Significant weight changes will be reviewed by the licensed nurse for assessment. The licensed nurse would then notify the provider and dietitian of significant weight changes, document notification, and notify the physician of recommendations made by the dietitian. Review of Resident 130's weights revealed on September 6, 2024, the resident was documented as weighing 131.5 pounds (lbs.) On October 3, 2024, the resident was documented as weighing 123.8 lbs., a 5. 86% loss in one month. The next documented weight in Resident 130's clinical record was not obtained until November 8. 2024, where the resident was documented as weighing 117.4 lbs., a 5.45% loss in one month. Further review of Resident 130's weights revealed the next weight was not obtained until December 11, 2024, where the resident was recorded as weighing 122.6 lbs. Review of Resident 130's progress notes and assessments failed to reveal evidence that the resident's weight loss was communicated to or addressed by the dietitian. Review of Resident 130's care plan and order summary failed to reveal any interventions added to the care plan or orders to address the resident's weight loss following the resident's weight loss. The above findings were discussed and confirmed with the Nursing Home Administrator on December 12, 2024, at approximately 9:50 a.m. 28 Pa. Code 211.5(f) Clinical Records 28 Pa. Code 211.12(d)(1)(5) Nursing Services 28 Pa Code: 211.10(c) Resident care policies

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 41765 Based on clinical records review and staff interview, it was determined that the facility failed to ensure medication to treat Diabetes (A group of metabolic disorders characterized by a high blood sugar level over a prolonged period of time) was made available for one of 35 residents reviewed (Resident 13). Findings include: A review of Resident 13's physician order dated August 28, 2024, revealed an order for Trulicity (A medication used to help lower blood sugar levels in people with type 2 diabetes) 4.5mg/0.5ml Inject 4.5 mg subcutaneously one time a day every Wednesday for Diabetes. A review of the October and November 2024, Medication Administration Record revealed Trulicity was not administered on October 9, 30, and November 13, 2024. Nursing progress notes dated October 9, 2024, October 30, 2024, and November 13, 2024, all indicated medication Trulicity (not administered), pharmacy notified. A review of the laboratory report dated April 10, 2024, revealed an HbA1c (A hemoglobin A1C test is a blood test that shows what your average blood sugar level was over the past two to three months) result of 8.1 (NORMAL: HbA1c below 5.7%, PREDIABETES: HbA1c 5.7-6.4%, DIABETES: HbA1c 6.5% and ABOVE). A laboratory report dated November 6, 2024, revealed an HbA1c result of 11.5. A review of the physician's progress notes dated November 21, 2024, revealed Resident 13's HbA1C was very high at 11 this month which is significantly higher than eight (8) in April 2024. The physician documented Unfortunately he/she did not get three doses of Trulicity recently which will impact his/her HbA1c. An interview with Employee E9 confirmed that Trulicity was not adminstered due to medication not being delivered from the pharmacy. The facility failed to ensure Resident 13's medication to help treat high blood sugar was consistently made available for the resident. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765 Based on clinical records review and staff interview, it was determined that the facility failed to provide a consistent non-pharmacological intervention (NPI) and failed to provide an appropriate indication for the use of as-needed psychotropic medication for one of five residents reviewed (Resident 164). Findings include: A review of Resident 164's physician's order dated October 21, 2024, revealed an order for Lorazepam (A medication used to treat Anxiety) 0.5 mg one tablet two times daily. An order for Lorazepam 0.5 mg one tablet by mouth every six hours PRN (as needed) for Anxiety was also made on the same day. A review of the December 2024, Medication Administration Record revealed that from [DATE], until December 12, 2024, aside from the schedule two times daily Lorazepam order, Resident 164 was administered with PRN Lorazepam order six times in 12 days. Clinical records review revealed that from December 1, 2024, until December 12, 2024, Resident 164 was administered with PRN Lorazepam four times with no NPI (non-pharmacological interventions- intervetnions that should be attempted prior to the administration of medications) before administering the medication. In addition, a record review revealed resident was administered with PRN Lorazepam six times with no appropriate indication. An interview with the Director of Nursing conducted on December 12, 2024, at 1:30 p.m., confirmed NPIs were not consistently provided and appropriate indications were not provided before administering the PRN Lorazepam. The facility failed to ensure Resident 164 was provided with an NPI before administering an anti-anxiety medication and appropriate indication was documented for the use of the anti-anxiety medication. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 41765 Based on a review of the facility's policy, observations, and staff interview, it was determined that the facility failed to ensure medications were properly stored and labeled for one of the two units observed (1 North). Findings include: A review of the facility policy titled Medication Storage undated, revealed medications and biologicals are stored properly, following manufacturers' or provider pharmacy recommendations to keep their integrity and to support safe, effective drug administration. The provider pharmacy dispenses medications in containers that meet state and federal labeling requirements. Medications are to remain in these containers and stored in a controlled environment. An observation on the 1 North short hall med cart was conducted on December 10, 2024, at 9:30 a.m., with the presence of licensed Employee E6. Observation of the top drawer of the medication cart revealed the following: five white tablets in a medication cup; 12 loose Allegra tablets (A medication used to treat allergies) tablets; and five loose Famotidine tablets (A medication used to treat heartburn). An interview with Employee E6 conducted on December 10, 2024, revealed that the white tablets in the medication cup were Acetaminophen (A medication used to treat mild pain) taken from its original container from another medication cart. Employee E6 was unable to provide an answer as to why Allegra and Famotidine were not in their original container. An observation on 1 North long hall medication cart was conducted on December 10, 2024, at 9:45 a.m., with the presence of Licensed Employee E7. Observation of the medication cart revealed the following: 53 loose tablets/pills (different colors and sizes) were scattered in the drawer where all medications on a blister pack were stored; an uncovered glucose gel tube with no pharmacy label; and a vial of used Lantus (A long-acting type of Insulin) dated (opened) October 25, 2024. An observation of the 1 North medication room was conducted on December 10, 2024, at 10:00 a.m., with the presence of licensed Employee E8. Observation of the medication room refrigerator revealed 23 Acetaminophen suppositories and 22 Bisacodyl suppositories (A medication used for constipation). Both medications were stored in a zip-lock bag with no pharmacy label. An interview with Employee E8 conducted on December 10, 2024, confirmed that the acetaminophen and Bisacodyl suppositories should be in their original container. The above was conveyed to the Nursing Home Administrator on December 12, 2024. The facility failed to ensure medications on the 1 North Unit medications carts and the room was properly stored and labeled. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa Code: 211.10(c) Resident care policies 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46166 Based on a review of select facility policies and procedures, clinical record review, observation, and staff interview, it was determined that the facility failed to implement enhanced barrier precautions for four out of 35 residents reviewed (Resident 11, Resident 59, Resident 64, and Resident 164). Findings include: Review of facility policy titled Enhanced Barrier Precautions, revision date January 8, 2024, states Enhanced Barrier Precautions (EBP) is based on the Centers of Disease Control & Prevention (CDC) guidance, Implementation of Personal Protective Equipment (PPE) use in nursing homes to prevent spread of multidrug-resistant organisms (MDROs). Review of Resident 11's clinical record revealed the resident was admitted [DATE], with an admitting diagnosis of sepsis (occurs when your immune system has a dangerous reaction to an infection, resulting in tissue damage and organ failure). Additional review of Resident 11's clinical record revealed an active order for indwelling foley catheter due to: neurogenic bladder (a condition where a problem in the brain, spinal cord, or central nervous system causes loss of bladder control), with a start date of July 5, 2024. Review of Resident 11's clinical record failed to reveal an order for enhanced barrier precautions. Observations conducted on December 11, 2024, and December 12, 2024, revealed that Resident 11 did not have any EBP signage or PPE located in or outside of his room. Interview conducted with the Director of Nursing (DON) on December 12, 2024, at 10:37 a.m. confirmed the facility failed to establish enhanced barrier precautions for Resident 11. Clinical records review revealed Resident 59 had an order for a GT (Gastrostomy tube- A medical device used to provide nutrition to people who cannot obtain nutrition by mouth) feeding for diagnosis of protein calorie malnutrition. Observation on December 9, 10, and 11, 2024, failed to reveal an EBP signage/communication or PPE set up in or outside of Resident 59's room. Clinical records review revealed Resident 64 had an order for a GT feeding . Observation on December 9, 10, and 11, 2024, failed to reveal an EBP signage/communication or PPE set up in or outside of Resident 64's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clinical records review revealed Resident 164 was admitted on [DATE], with a diagnosis of small bowel cancer. The resident had an admission order for a PICC line (Peripherally Inserted Central Catheter- a thin, flexible tube inserted into a vein in the vein near arm and threaded into a large near the heart) to the left upper arm, a foley catheter for urinary retention and a GT attached to a collection bag for abdominal decompression. Observation and interview with the Resident 164 confirmed that presence of a PICC line to the left upper arm, indwelling foley catheter, and GT attached to a collection bag. Observation on December 9, 10, and 11, 2024, failed to reveal an EBP signage/communication or PPE set up in or outside of Resident 164's room. An interview with licensed nurse Employee E6 conducted on December 12, 2024 at approximately 10:00 a.m. , revealed that residents requiring EBP needed to have a signage by the door for communication and PPE set up outside of the resident's room. Employee E6 acknowledged the absence of the signage and PPE set up for Resident 64 and 164 and reported that she/he just notified the staff responsible in placing the signage and PPE's for the resident mentioned above. An interview with the Regional nurse Employee E9 and Director of Nursing on December 12, 2024, at 1:00 p. m., confirmed EBP process was not implemented for Resident 59, 64, and 164. 483.80(a)(1)(2)(4)(e)(f) Infection Prevention and Control 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services