

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395740	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/28/2024
NAME OF PROVIDER OR SUPPLIER West Chester Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 800 West Miner Street West Chester, PA 19382	

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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765</p> <p>Based review of the facility's policy, clinical records review, and staff interviews, it was determined that the facility failed to accurately assess a sacral wound, inform the physician regarding the wound condition, and accurately assess weekly skin wounds resulting in an advanced wound stage with undermining for one of two residents reviewed (Resident R1).</p> <p>Findings include:</p> <p>Review of the facility's policy titled Pressure Ulcers/Skin Breakdown - Clinical Protocol, revised in April 2018, revealed that the nurse shall describe and document a full assessment of pressure sore including location, stage, length, width, and depth, presence of exudates or necrotic tissue.</p> <p>Review of Resident R1's clinical records revealed resident was admitted to the facility on [DATE], with a diagnosis of Parkinson's Disease (disorder of the central nervous system that affects movement, often including tremors).</p> <p>Resident R1's admission skin assessment dated [DATE], revealed resident skin was intact.</p> <p>Review of Resident R1's Braden Scale Assessment (tool used for predicting pressure wound risk) dated July 2, 2023, revealed resident was a high risk for developing a pressure sore.</p> <p>Review of Resident R1's current skin care plan revealed interventions that include Documenting skin checks weekly and as needed and evaluating and documenting the wound healing process. Report significant changes and declines to the provider and follow up as indicated.</p> <p>Review of Resident R1's clinical record including nursing progress note dated November 14, 2023, at 2:51 p. m., revealed resident was observed with a MASD (Moisture-Associated Skin Damage-inflammation and erosion of the skin caused by prolonged exposure to various sources of moisture, including urine/stool, perspiration, exudate, or ostomy) to the sacrum (tail bone). The MASD area was treated with a Zinc Oxide.</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
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R1's clinical record including wound assessment note dated December 1, 2023, by the wound care nurse, licensed Employee E3, revealed the sacral wound had measurements of 7.1 x 4.1 x 0.2 cm with 50% slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy, and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed). Employee E3 indicated the sacrum wound was Stage 2 (Partial-thickness skin loss with the exposed dermis, granulation tissue, slough, and eschar are not present).</p> <p>Review of Resident R1's weekly skin assessment dated [DATE], completed by licensed nurse Employee E4, revealed Resident R1's sacral wound was identified as an MASD despite a previous wound assessment completed by the wound nurse (December 1, 2023), indicating the resident's sacral wound had a 50% slough.</p> <p>Review of Resident R1's wound assessment dated [DATE], conducted by Employee E3, revealed resident's sacral wound measured of 5.7 x 4.1 x 0.2 cm with 10% slough. The wound was assessed as Stage 2.</p> <p>Review of Resident R1's weekly skin assessment dated [DATE], by licensed nurse Employee E5, revealed Resident 1's sacral wound was a MASD despite a previous wound assessment completed by the wound nurse (December 8, 2023), indicating the resident sacral wound had a 10% slough.</p> <p>Review of Nurse Practitioner's (NP) wound consult report dated December 15, 2023, revealed the following: Worsening sacral pressure unstageable (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar). The wound had a measurement of 9.6 x 2.1 x 1.3 cm., a calculated area of 20.16 sq cm., with undermining (Occurs when significant erosion occurs underneath the outwardly visible wound margins resulting in more extensive damage beneath the skin surface) 11 o'clock to 1 o'clock of 2.0 cm., with 50-74% slough, and 25-49% eschar. A wound treatment of Santyl (topical medication used for removing damaged or burned skin to allow for wound healing and growth of healthy skin) was ordered.</p> <p>Review of Resident R1's weekly skin assessment dated [DATE], completed by licensed nurse Employee E6, revealed Resident's sacral wound was a MASD despite wound NP's documentation on December 15, 2023, that Resident 1's sacral wound was unstageable with undermining.</p> <p>Review of Resident R1's clinical record revealed the sacral wound was last assessed by the wound nurse on December 8, 2023, (indicative of a stage 3 wound) but was unable to determine the date when the wound started to further decline (increased in size, depth, presence of slough and scar, and undermining) since Employee E6's skin check performed on December 13, 2023, indicated that the wound was of MASD origin.</p> <p>Interview with the Director of Nursing (DON) conducted on February 28, 2024, at 10:00 a.m., revealed resident's skin check conducted weekly by a licensed nurse. The facility also has a wound care nurse and wound consultant (Nurse Practitioner) who follows the wound weekly.</p> <p>Interview with conducted with Employee E3 on February 28, 2024, at 11:00 a.m., confirmed that Resident R1's wound assessment completed on December 1, 2023, was a stage 3 Pressure Ulcer (Full thickness skin loss) and not a stage 2. Employee E3 indicated the wound practitioner did not observe the resident's wound but was notified the resident's wound developed to a stage 2 pressure ulcer. Employee E3 indicated the facility protocol wound treatment for Stage 2 was followed with a Medi-honey wound treatment ordered.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the wound nurse conducted on February 28, 2024, failed to reveal an answer as to why licensed nurses Employee E4, E5, and E6 assessed Resident 1's sacral wound as MASD despite previous assessments indicating the sacral wound was already a Stage 3 on December 1, 2023, and unstageable on December 15, 2023.</p> <p>An interview with Employee E3 conducted on February 28, 2024, at 11:00 a.m., confirmed that Resident 1's wound assessment completed on December 8, 2023, was a stage 3 and not a stage 2. Employee E3 reported that the physician was notified that the resident's sacral wound was a stage 2 and not a stage 3, previous treatment of Medi-honey was continued.</p> <p>Interview conducted with the Director of Nursing on February 28, 2024, at 1:00 p.m., revealed the resident's primary physician/NP was notified of a worsened wound of MASD to pressure on December 1, 2023, but did not indicate the resident's wound is categorized as Stage 3 wound.</p> <p>The above information was conveyed to the Director of Nursing and Nursing Home Administrator on February 28, 2024, at 2:00 p.m.</p> <p>The facility failed to ensure Resident 1's sacral wound was accurately assessed and monitored resulting in the wound progressing to an unstageable stage with undermining.</p> <p>28 Pa. Code 201.18 (b)(1)(e)(1) Management Previously cited 6/15/23</p> <p>28 Pa. Code 211.5(h)Clinical records Previously cited 6/15/23</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing Services Previously cited 6/15/23</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>41765</p> <p>Based on clinical record review, pharmacy record review, and staff and resident interview it was determined the facility failed to ensure medications were available for resident for one of the two residents reviewed (Resident CL1).</p> <p>Findings include:</p> <p>Review of Resident CL1's physician order dated January 26, 2024, revealed an order for Gabapentin Oral Capsule 300mg Give 300mg orally at bedtime for neuropathy (numbness and pain from nerve damage, usually in the hands and feet).</p> <p>Review of the January 2024 Medication Administration Record (MAR) revealed Gabapentin was not administered to the resident until January 31, 2024, four days after the medication was ordered by the physician. The resident missed four doses of the Gabapentin 300mg medication.</p> <p>Review of the pharmacy records revealed the medication was not delivered by the pharmacy until January 31, 2024.</p> <p>Interview conducted with the Director of Nursing on February 28, 2024, confirmed that Resident CL1 was not administered with Gabapentin due to medication not being available from the pharmacy.</p> <p>The facility failed to ensure Resident CL1's medication was available from the pharmacy.</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing Services</p> <p>Previously cited 6/15/23.</p>