STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395740	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Chester Rehabilitation and Healthcare Center	800 West Miner Street West Chester, PA 19382

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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 clinical records review and staff interview, it was determined that the facility failed to notify the physician of the significant weight change of two of the 32 residents reviewed (Resident 18 and 161). Findings include: Review of Resident 18's diagnosis list includes End Stage Renal Disease (ESRD- Where kidney function has declined to the point that the kidneys can no longer function on their own), and dependence on Hemodialysis (A process of purifying the blood of a person whose kidneys are not working normally). Review of Resident 18's weights and vitals dated April 2, 2024, revealed a weight of 182 pounds, and April 7, 2024, revealed a weight of 205.8, a 13.8% significant weight gain in five days. A re-weight was done on April 16, 2024, which revealed a weight of 205 pounds. Review of Resident 18's clinical record failed to reveal that the physician was notified of Resident 18's significant weight change. Review of Resident 161's diagnosis list includes ESRD and Dependence on Hemodialysis. Review of Resident 161's weights and vitals dated March 1, 2024, revealed a weight of 175.3 pounds, and March 5, 2024, revealed a weight of 227.5 pounds a 29.78 % significant weight gain in four days. Re-weight was not done until March 27, 2024, which revealed a weight of 218. 5, a 24.64% significant weight gain from the March 1, 2024, weight. Review of Resident 161's clinical record revealed the physician was not notified of Resident 161's significant weight change until April 17, 2024, six weeks after a significant weight change was identified. Interview conducted with the Director of Nursing on April 29, 2024, at 11:00 a.m., confirmed Resident 18's physician was not notified of the significant weight change, and Resident 161's physician was not notified of the resident's significant weight change timely. 28 Pa. Code 201.18(e)(3) Management (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 211.12(c)(d)(1)(3)(5) Nursing services

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 41765 Based on clinical records review, facility documentation review, and staff interview, it was determined that the facility failed to comprehensively investigate an injury of unknown origin for one of the 32 residents reviewed (Resident 37). Findings include: Review of Resident 37's diagnosis list includes Dementia (term used to describe a group of symptoms affecting memory, thinking, and social abilities severely enough to interfere with daily life), Cancer of the Larynx, Acute Respiratory Failure, and generalized muscle weakness. Review of the Significant Change Minimum Data Set (MDS- standardized assessment tool that measures health status in long-term care residents) dated June 30, 2023, revealed that the resident had a severe cognitive impairment and required extensive with one-person assistance with bed mobility and transfers. Review of the physician notes dated July 28, 2023, revealed worsening bilateral hip pain despite conservative measures with pain medications, an X-ray was ordered. Review of the nursing progress notes dated July 29, 2023, at 4:15 a.m., revealed a call was received from the imaging company and was informed that the x-ray result of the bilateral hips with pelvis done on July 28, 2023, revealed Bilateral sub capital fractures of undetermined age involving the hips without dislocation. The physician was notified and ordered to transfer the resident to the hospital. Review of the nursing progress notes dated July 29, 2023, revealed Resident 37 was admitted to the hospital with a diagnosis of bilateral hip fracture. Review of the facility documentation dated July 29, 2023, revealed an interview with the resident who denied trauma to the area or abuse. The resident reported chronic pain in the lower back and hips but got worse over the last week. The resident denied falling and does not know how the injury occurred. A review of the same document revealed no interviews/statements from staff who could have an encounter or cared for the resident. Interview was conducted with licensed employee E3 on April 29, 2024, at 11:00 a.m. Employee E3 reported that for injury of unknown origin, an interview/statement of staff that cared for the resident for the last 48 hours should have been completed. Interview with the Nursing Home Administrator on April 29, 2023, at 2:00 p.m., confirmed that there were no staff interviews/statements completed for Resident 37's bilateral hip fracture of unknown origin. The facility failed to ensure Resident 37's bilateral hip fracture of unknown origin was comprehensively investigated. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 201.18(e)(3) Management 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 46166 Based on clinical record review and interview with staff, it was determined that the facility failed to notify the State Long-Term Care (LTC) Ombudsman's office of residents transferred or discharged for one of six residents reviewed (Residents 369). Findings include: Review of Resident 369's clinical record revealed a nursing progress note dated March 21, 2024, revealed that the resident had a new order to be sent to the hospital due to being unresponsive. Further review of Resident 369's clinical record failed to reveal documented evidence of the State Ombudsman's office notified of Resident 369's transfers from the facility to the hospital. Interview with the Nursing Home Administrator (NHA) on April 29, 2024, at 10:40 a.m. confirmed that the facility did not notify the State Ombudsman's office when Resident 369 was transferred to the Hospital. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(a) Management 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 201.29(a) Resident rights

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 41765 Based on clinical records review and staff interview, it was determined that the facility failed to develop a comprehensive care plan for one of 32 residents reviewed (Resident 95) Findings include: Review of Resident 95's diagnosis list includes Dementia (term used to describe a group of symptoms affecting memory, thinking and social abilities severely enough to interfere with daily life), Bpolar Disorder (condition associated with episodes of mood swings ranging from depressive lows to manic highs), and Anxiety disorder. Review of Resident 95's Quarterly Minimum Data Set (MDS- standardized assessment tool that measures health status in long-term care residents) dated February 22, 2024, revealed that the resident had a severe cognitive impairment. Review of the Psychiatry notes dated January 10, 2024, revealed resident was previously on another facility with history of at least four prior psychiatry hospitalization s and previous attempts of hurting self. Resident on medication management. Review of Resident 95's care plan revealed no plan of care developed for resident's behavior (previous attempt to hurt self). Interview with the Nursing Home Director conducted on April 29, 2024, at 1:30 p.m., confirmed that Resident 95's behavior of previous attempts to hurt self plan of care was not developed. The facility failed to ensure a comprehensive care plan was developed for Resident 95's behavior of previous attempts to hurt self. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 201.18(e)(3) Management 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35913 Based on a review of established guidelines for Cardiopulmonary Resuscitation (CPR), the facility's policies and residents' clinical records, as well as staff interviews, it was determined that the facility failed to ensure that CPR was provided in accordance with established facility policy and procedure for one of five residents reviewed (Resident 288), creating a situation in which the residents were placed in Immediate Jeopardy related to failing to perform cardiopulmonary resuscitation. Findings include: Review of facility policy titled Emergency Procedure - Cardiopulmonary Resuscitation with a revised date of February 2018; revealed under section titled General Guidelines and Number Six indicated If an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR/BLS shall initiate CPR unless: a. it is known that a Do Not Resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual; or b. there are obvious signs of irreversible death (e.g., rigor mortis). Further review of facility policy titled Emergency Procedure - Cardiopulmonary Resuscitation revealed Number Seven under General Guidelines indicating; If the resident's DNR status is unclear, CPR will be initiated until it is determined that there is a DNR or a physician's order not to administer CPR. Review of clinical record of Resident 288 revealed the resident was admitted to the facility on [DATE], as a short-term respite admission on hospice service with diagnoses including but not limited to Essential Hypertension, Cardiomyopathy, Heart Failure, and Aortic Stenosis (severe). Review of Resident 288's clinical record revealed Resident 288 had a physician's order for full life sustaining interventions of Cardiopulmonary Resuscitation dated [DATE]. Review of Resident 288's progress note completed by RN Supervisor, dated [DATE], at 2:08 a.m. indicated This RN was called by nurse that the resident had stopped breathing. Resident unresponsive to external stimuli, no pulmonary activity was noted. Not responding to sternal rub. Apical and Radial pulse not absent for 60 seconds. Pupils were fixed and Dilated. Resident was pronounced CTB at 2230 on [DATE]. Daughter [Name Withheld] made aware. [Name withheld] hospice and [name withheld] geriatrics made aware of death. Body released to [identified] funeral home. Interview conducted via telephone on [DATE] at 12:35 p.m. with RN Supervisor, Employee E3 revealed that due to resident's hospice status and full code status, CPR was withheld. Further interview with Employee E3 revealed, RN supervisor initiated a telephone conversation with resident's daughter who informed the RN Supervisor the family does not wish to have CPR performed on the resident. Review of Resident 288's clinical record revealed documents faxed to the facility by hospice provider on [DATE], at 10:47 a.m. including Patient Information Report indicated daughter was emergency contact only but an alternative family member was legal representative. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of Resident 288's hospice documents including Patient Information Report revealed Resident 288 also diagnosed with Congestive Heart Failure. Further review of hospice documents revealed a progress note dated [DATE] by attending hospice physician who indicated Resident 288 was FULL CODE. Interview with the Nursing Home Administrator and the Director of Nursing on [DATE] revealed that they were aware that staff did not provide CPR to Resident 288 in accordance with the code status, and the facility's policy. On [DATE], at 3:30 p.m. the Nursing Home Administrator was informed that Immediate Jeopardy was identified due to Licensed staff failing to provide CPR in accordance with a resident's physician's order and the facility policy. Nursing Home Administrator was provided the Immediate Jeopardy template at approximately 3:35 p.m. The facility submitted an acceptable immediate action plan on [DATE]:35 p.m. that included the following actions: A facility wide review of all residents' life sustaining code status to ensure each resident's advanced directive and physician-ordered code status was in place. The facility developed an education plan for all licensed nurses regarding the facility's CPR policy including general guidelines, preparation and emergency procedure for all residents; to ensure that CPR will be provided in accordance with each resident's advanced directive and physician orders and further education on where to find the code status of residents. The plan also included to actively hold Code Blue drills (simulated event whereby staff respond to a resident experiencing cardiac arrest) with staff, and to complete ongoing audits. An audit of the eleven hospice residents including nine with Do Not Resuscitate (DNR) and Full life sustaining measures were reviewed. The Immediate Jeopardy was lifted on [DATE], at 10:15 a.m. when it was confirmed that the facility provided licensed nursing staff of 11 LPN's (Licensed Practical Nurses) and 4 RN's (Registered Nurses) with education regarding providing CPR in accordance with residents' advanced directives, physician's orders and the facility's policy and completed a Code Blue drill to ensure that licensed nurses were prepared to respond to situations that required CPR. Staff were able to identify resident's code status is located on the Medication Administration Record (MAR) which is accessible to all licensed staff. Any remaining staff were scheduled to receive the education prior to the start of their next shift. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 201.18(e)(3) Management 28 Pa. Code 211.12(c)(d)(1)(3)(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. **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 ensure wound treatment was consistently completed and wound recommendation from a wound consultant was followed for a surgical wound for one of 32 residents reviewed. Finding include: Review of the Nurse Practitioner's (NP) progress notes dated March 11, 2024, revealed Resident 18 was readmitted to the facility on [DATE], with a surgical wound post incision and drainage of a hematoma (pool of mostly clotted blood that forms in an organ, tissue, or body space) to the left lateral leg. A wound treatment order to cleanse the wound with cleanser, apply Collagen to the base of the wound then cover with dressing daily and as needed was ordered. Review of Resident 18's April 2024, Treatment Administration Record revealed that wound treatment to Resident 18's left lateral surgical wound was not done on April 7, 14, 16, 20, and 21, 2024. Review of the wound NP's notes dated April 18, 2024, revealed Resident 18's surgical wound to the left lateral leg was evaluated, a new wound treatment recommendation was made, to cleanse the wound with cleanser, apply Medihoney (A dressing that aids and support debridement and a moist wound healing environment in acute and chronic wounds and burns), cover with dressing daily and as needed. Review of the April 2024, TAR revealed that the wound NP's surgical wound treatment recommendation made on April 18, 2024, was not placed as an order, and therefore was not implemented. Interview with the Director of Nursing was conducted on April 29, 2024, at 11:00 a.m., The Director of Nursing (DON) reported that the wound NP's recommendation was supposed to be relayed to the physician for approval. The facility was unable to provide documented evidence that the physician was notified of the wound NP's new surgical wound recommendations. The DON was unable to provide an answer as to why the wound NP's surgical wound treatment recommendation was not implemented. The DON was unable to provide an explanation of the missed surgical wound treatment on April 7, 14, 16, 20, and April 21, 2024. The facility failed to ensure Resident 18's surgical wound treatment to the left lateral leg was consistently done and wound recommendation of the wound specialist was followed. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46166 Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to follow physician's order regarding pre dialysis and post dialysis weight monitoring and to maintain ongoing communication with the dialysis center for four of four residents receiving dialysis (Residents 18, 98,161, and Resident 369). Findings include: Review of Resident 18's diagnosis list includes End Stage Renal Disease (ESRD), and dependence on Hemodialysis (process of purifying the blood of a person whose kidneys are not working normally) Review of Resident 18's physician's order dated April 4, 2024, revealed an order for pre and post-dialysis weights, ensured recorded in the communication binder for dialysis did Review of Resident 18's dialysis binder revealed no information on the pre and post-dialysis weights on the following dates: April 10, 15, and April 17, 2024. Review of Resident 98's diagnosis list includes ESRD and dependence on Hemodialysis. Review of Resident 98's physician's order dated December 8, 2023, revealed an order for pre and post-dialysis weights, ensure recorded in the communication binder for dialysis two times a day every Monday, Wednesday, and Friday. Review of Resident 98's dialysis binder revealed no pre and post-dialysis weight on April 8, and 10, 2024, and no post-dialysis weight on April 24, 2024. Review of Resident 161's diagnosis list includes ESRD and dependence on Hemodialysis. Review of Resident 161's physician's order dated January 23, 2024, revealed an order for pre and post-dialysis weights, which was recorded in the communication binder for dialysis. Review of Resident 161's dialysis binder revealed no information on the pre and post-dialysis weights on April 5, 8, 10, and April 15, 2024. No post-dialysis weight was recorded on April 12, 2024, and no pre weight documented on April 22, and April 24, 2024. Interview with the Nursing Home Administrator conducted on April 29, 2024, at 1:30 p.m., confirmed that there were no documented pre and post-dialysis weights on the dates mentioned above for Residents 18, 98, and 161. Review of Resident 369's clinical record indicated Resident 369 was admitted to the facility on [DATE]. Review of Resident 369's Minimum Data Set (MDS - periodic assessment of care needs) dated February 18, 2024, indicated diagnoses of end-stage renal disease (ESRD - an inability of the kidneys to filter the blood), and dependence on renal dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 369's physician's order dated March 20, 2024, indicated Resident 369 received dialysis treatment three times a week on Monday, Wednesday, and Friday. Review of Resident F369's order dated March 20, 2024, indicated a Dialysis Communication Tool was to be completed and sent to dialysis with Resident 369 every Monday, Wednesday, and Friday. Review of Resident 369's clinical record revealed an additional physician order dated March 20, 2024, indicating Record pre and post dialysis weight in communication book. Interview conducted on April 29, 2024, at 12:46 p.m. the Nursing Home Administrator (NHA) reported the facility does not have a communication book for Resident 369. NHA stated If they haven't given it to you by now, then we don't have it. 28 Pa. Code 211.10(c)(d) Resident Care Policies 28 Pa. Code 211.12 (d)(2) Nursing Services 28 Pa. Code 211.12(d)(1)(5) Nursing Services 28 Pa. Code: 201.14(a) Responsibility of licensee 28 Pa. Code: 201.18(b)(1) Management

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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. 37789 Based on clinical record review, it was determined that the facility failed to ensure one of 32 residents reviewed was free of unnecessary psychotropic medication (Resident 42). Findings include: Review of Resident 42's clinical record revealed a physician's order dated November 7, 2023, for trazodone (antidepressant medication) 50 milligrams (mg) 1 tablet by mouth at bedtime. Review of Resident 42's Consultant Pharmacist Report dated November 8, 2023, revealed the pharmacist questioned if the resident's trazodone was still needed, with the physician responding Defer to psych. Review of Resident 42's psychiatrist note from January 24, 2024, revealed that the resident is currently on 3 antidepressants. Trazodone previously ineffective. Recommend taper off trazodone by reducing the dose to 25mg 1 tablet by mouth at bedtime. Review of Resident 42's January, February, and March 2024 Medication Administration Records revealed the resident continued to receive Trazodone 50 mg until March 28, 2024. Review of Resident 42's progress notes revealed a nurse's note dated February 10, 2024, which stated: Resident seen sleeping more than usual during shift. Attempted more than once to awakening but he verbally expressed he was more tired than usual. Ate 20% of his breakfast and slept through lunch. Meds held due to resident being sleep. Vitals stable . Resident denied any pain but verbally expressed he felt too tired to do anything. MD notified. Review of Resident 42's next psychiatrist note dated March 27, 2024, revealed that the resident complained of low energy, daytime sleepiness at times with recommendations again to reduce the resident's trazodone dose from 50mg to 25mg. Interview with the Director of Nursing on April 29, 2024, at 11:30 a.m. confirmed that the facility did not follow Resident 42's psychiatrist recommendations from January 24, 2024, to reduce the resident's trazodone dose until March 28, 2024. 28 Pa. Code 211.2(a) Physician services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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	395740	A. Building B. Wing	05/06/2024

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 35913 Based on a review of their job descriptions it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) did not effectively manage the facility to ensure that Cardio Pulmonary Resuscitation was provided in accordance with the facility policy and procedures to residents that are a full code. Findings include: Review of the job description for the NHA revealed the essential function is responsible for planning and is accountable for all activities and departments of the Center subject to rules and regulations (put into affect) by government agencies to ensure proper healthcare services to residents. Review of the job description for the DON revealed the responsibility of the job position is overall accountability for providing leadership, direction and administration of day-to-day operations associated with direct patient care activities, nursing practice, clinical education and development, including continuing improvement in nursing services and to staff to meet patient/residents and their families' needs and expectations. The findings in this report identified that the facility failed to ensure that CPR was provided in accordance with the facility policy and procedures a resident was a FULL CODE. The NHA and DON failed to fulfill their essential job duties that the federal and state guidelines and regulations were followed. Refer to F678 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 207.2(a) Administrator's Responsibility 28 Pa. Code 211.12(d)(1)(5) Nursing Services 28 Pa. Code 211.12(d)(2)(3) Nursing Services