STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395936	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wayne Woodlands Manor	37 Woodlands Drive Waymart, PA 18472

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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 26142 Based on a review of clinical records and the facility's abuse prohibition policy and staff interviews, it was determined the facility failed to timely report alleged abuse of one resident out of 14 sampled (Resident 1) to the State Survey Agency. Findings include: A review of Resident 1's clinical record revealed diagnoses of dementia (overall term that describes a group of symptoms associated with a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities) depression, and muscle weakness. A review of the resident's admission MDS Assessment, dated February 22, 2024, (Minimum Data Set - a federally mandated standardized assessment completed a intervals to plan resident care) revealed that the resident was severely cognitively impaired and used a wheelchair for mobility. A report from a facility staff member, who wished to remain anonymous, revealed that on May 16, 2024, Employee 1, a nurse aide, held Resident 1 by the back of the resident's sweater and the was screaming at the resident at the top of her lungs. Employee 1 was escorted out of building, but was subsequently permitted to return to duty. An interview with the nursing home administrator (NHA) and director of nursing (DON) on May 28, 2024, at 12:00PM confirmed that on May 16, 2024, Employee 1. a nurse aide. was removed from the building. According to the NHA and DON, Employee 1 became upset when Resident 1 tried to get out of her wheelchair and the employee grabbed the resident and pulled her back, pushing her into the chair. Resident 1 and Employee 1 began to scream. The NHA stated the facility obtained statements from staff on May 16, 2024, but did not report the alleged physical and verbal abuse of Resident 1 by Employee 1 to the State Survey Agency. A statement from Employee 2, an LPN, dated May 16, 2024, regarding the incident revealed that she heard Resident 1 yelling help get away from me! The employee observed the resident in the bathroom screaming and crying pulling at her brief. Employee 1 was kneeling in front of the resident. The resident was assisted back to her chair and was heard crying and saying she bumped me and I am not a bad girl. Later the resident was attempting to stand from her wheelchair and Employee 3 saw Employee 1 grab the resident by the middle of her shirt with the wheelchair in between them. (continued on next page)

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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A statement written by Employee 3, an LPN. on May 16, 2024 revealed that she heard Resident 1 scream out in a way that the employee described as never hearing her (the resident) scream like that before. Employee 2 stated she saw Employee 1 pulling the resident by her sweater and wheelchair backward down the hallway. Employee 2 told Employee 1 to remove herself from the resident and then Employee 1 began arguing with the nurse. The resident was heard to be crying and stating don't push me, I am not a bad girl, why she do this to me. A statement from the accused Employee 1 regarding the incident indicated that when she was changing Resident 1, the resident kicked her and she said she moved so she couldn't be kicked again. She stated that the resident attempted to punch her in the head and she blocked the resident, when she tried to punch her. She stated that's what she's told she can do. She stated the resident continued screaming at the top of her lungs and then staff came in to help her get the resident's brief on. She was told to leave the room. A little while later Employee 1 saw Resident 1 attempting to go into another resident's room she stated she caught her trying to get out of her wheelchair. A review of the facility's policy entitled Abuse Prevention and Procedures: Reporting dated as reviewed May 14, 2024 indicated for allegations of physical, verbal and mental abuse, neglect or mistreatment the facility is to: Notify the State regional licensing agency (DOH) of any allegations of abuse utilizing the Electronic Event Reporting System via the internet within 24 hours. In the case of computer malfunction, notification will occur within 24 hours and will then be followed by electronic filing. Notify Area Agency on Aging immediately and follow up with a written report within 48 hours Local law enforcement will be notified immediately of any allegations of misappropriation of property. Law enforcement will conduct an independent investigation in conjunction with the facility. If an alleged perpetrator is identified, a PB-22 will be submitted via the Electronic Event Reporting System via the internet within 5 working days of the reported allegation. Appropriate actions will be taken in regard to continued employment. There was no documented evidence that this allegation was reported to the State Survey Agency within 24 hours according to the 28 PA Code Long Term Care Licensure Regulations. After surveyor inquiry, the facility reported the allegation on May 28, 2024. 28 Pa. Code 201.14(c) Responsibility of licensee 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a)(c) Resident Rights

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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. 26142 Based on a review of clinical records, the facility's abuse prohibition policy and information provided by the facility it was determined the facility failed to promptly conduct a thorough investigation to rule out abuse and implement corrective action and submit the results of the completed investigation to the State Survey Agency within five working days of the incident as evidenced by one of 14 residents reviewed (Resident 1) Findings include: A review of the facility policy entitled Abuse Prevention and Procedures dated as reviewed May 14, 2024 revealed: All complaints, grievances, or events that may constitute abuse, neglect, mistreatment, misappropriation of resident property and exploitation will be investigated thoroughly and will commence immediately upon receipt of the allegation. Investigation regarding all concerns, incidents and grievances will be initiated immediately by the supervisor on duty. The Administrator or Designee will be notified immediately of any allegations of abuse. The Administrator or Designee will direct the investigative process. All supervisory staff will be made aware of abuse or related issues of allegations and will be responsible to monitor staff behavior. When an alleged perpetrator is identified he/she will be immediately removed from the resident care area, will be made aware of the nature of the allegation, and will be provided opportunity to provide a written statement regarding the allegation. The alleged perpetrator will be removed from the facility and will be placed on a leave of absence until the investigation is completed. Staff, resident representative, family, visitors and cognitively intact residents that may have observed events at the time of the allegation will be interviewed in regard as to what was witnessed and knowledge of the incident. Signed statement will be obtained. Inform all staff that knowingly withholding information, will lead to serious consequences. Withholding information makes one just as guilty as the offender. Based on the information compiled during the investigative process, substantiation or un-substantiation will be determined. If the allegation is substantiated, the perpetrator will be immediately terminated, if not he/she may return to work, but may be reassigned to another unit. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	If substantiation is determined all state and local agencies will be notified as required. Notify the State regional licensing agency (DOH) of any allegations of abuse utilizing the Electronic Event Reporting System via the internet within 24 hours. In the case of computer malfunction, notification will occur within 24 hours and will then be followed by electronic filing. If an alleged perpetrator is identified, a PB-22 will be submitted via the Electronic Event Reporting System via the internet within 5 working days of the reported allegation. A review of Resident 1's clinical record revealed diagnoses of dementia (overall term that describes a group of symptoms associated with a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities) depression, and muscle weakness. A review of the resident's admission MDS Assessment, dated February 22, 2024, (Minimum Data Set - a federally mandated standardized assessment completed a intervals to plan resident care) revealed that the resident was severely cognitively impaired and used a wheelchair for mobility. A report from a facility staff member, who wished to remain anonymous, revealed that on May 16, 2024, Employee 1, a nurse aide, held Resident 1 by the back of the resident's sweater and the was screaming at the resident at the top of her lungs. Employee 1 was escorted out of building, but was subsequently permitted to return to duty. An interview with the nursing home administrator (NHA) and director of nursing (DON) on May 28, 2024, at 12:00PM confirmed that on May 16, 2024, Employee 1. a nurse aide. was removed from the building. According to the NHA and DON, Employee 1 became upset when Resident 1 tried to get out of her wheelchair and the employee grabbed the resident and pulled her back, pushing her into the chair. Resident 1 and Employee 1 began to scream. The NHA stated the facility obtained statements from staff on May 16, 2024, but did not report the alleged physical and verbal abuse of Resident 1 by Employee 1 to the State Survey Agency. A statement from Employee 2, an LPN, dated May 16, 2024, regarding the incident revealed that she heard Resident 1 yelling help get away from me! The employee observed the resident in the bathroom screaming and crying pulling at her brief. Employee 1 was kneeling in front of the resident. The resident was assisted back to her chair and was heard crying and saying she bumped me and I am not a bad girl. Later the resident was attempting to stand from her wheelchair and Employee 3 saw Employee 1 grab the resident by the middle of her shirt with the wheelchair in between them. A statement written by Employee 3, an LPN. on May 16, 2024 revealed that she heard Resident 1 scream out in a way that the employee described as never hearing her (the resident) scream like that before. Employee 2 stated she saw Employee 1 pulling the resident by her sweater and wheelchair backward down the hallway. Employee 2 told Employee 1 to remove herself from the resident and then Employee 1 began arguing with the nurse. The resident was heard to be crying and stating don't push me, I am not a bad girl, why she do this to me. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A statement from the accused Employee 1 regarding the incident indicated that when she was changing Resident 1, the resident kicked her and she said she moved so she couldn't be kicked again. She stated that the resident attempted to punch her in the head and she blocked the resident, when she tried to punch her. She stated that's what she's told she can do. She stated the resident continued screaming at the top of her lungs and then staff came in to help her get the resident's brief on. She was told to leave the room. A little while later Employee 1 saw Resident 1 attempting to go into another resident's room she stated she caught her trying to get out of her wheelchair. When interviewed on May 28, 2024 at 12:30PM., the Nursing Home Administrator and Director of Nursing confirmed the facility failed to provide evidence of timely and complete investigations alleged resident abuse and submission of completed investigations to the State Survey Agency within five working days of the occurrence 28 Pa. Code 201.14(c) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 201.29 (a)(c)Resident Rights