

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395936	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/05/2024
NAME OF PROVIDER OR SUPPLIER Wayne Woodlands Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - 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** 26142</p> <p>Based on a policy review, clinical record review, select document and investigation review, and resident and staff interviews, it was determined that the facility failed to protect residents from sexual abuse, resulting in psychosocial harm for one of four residents reviewed (Resident 1).</p> <p>Findings included:</p> <p>Review of current facility policy, titled Abuse, neglect, mistreatment, misappropriation of resident property and exploitation prevention, revised March 26, 2024, revealed that it is the policy that abuse, neglect, misappropriation of resident property, and exploitation of residents will not be tolerated in any manner. All staff will be provided education related to abuse and components to prevent potential abuse.</p> <p>A review of Resident 1's clinical record revealed an admitted [DATE], with diagnoses that included atherosclerotic heart disease (condition where a sticky substance made of cholesterol, fat, calcium, and other materials builds up inside the walls of the arteries) and diabetes (condition that affects blood sugar levels).</p> <p>A quarterly Minimum Data Set assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated May 23, 2024, indicated that the Resident was moderately cognitively impaired, with a BIMS (Brief Interview for Mental Status - a tool to assess cognitive status) score of 7.</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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a facility investigation report dated August 2, 2024, at 7:15 AM, revealed that on that date and time Resident 1 was about to receive morning care when she disclosed to Employee 1 (Nurse Aide [NA]) that during the night (the prior 11 PM to 7 AM shift) a man came into her room, pinned her down and fucked her, and that she was sore down there. Per Employee 1, the Resident was in bed, her brief was in place, and her pajama bottoms at her knees. Employee 1 reported this to Employee 2 (Licensed Practical Nurse [LPN]), and both then reported it to the Director of Nursing (DON). The DON attempted to do a physical assessment; however, when staff attempted, the Resident refused to have her bra removed. When staff attempted to help the Resident undress her lower body, she became guarded and started crying, stating I cannot do this. It hurts and I am frightened. The examination immediately ceased. The Resident's brief had been changed related to being soaked with urine. In an attempt to maintain evidence, the Resident's brief was kept in the bathroom, the sheets were left untouched, and her clothing was kept on Resident 1. The State Police, Physician, responsible party, and Department of Aging were notified. Resident 1 was taken to the hospital for evaluation.</p> <p>Review of Resident 1's facility transfer to the hospital form dated August 2, 2024, at 7:48 AM, revealed she had pain in her groin and she alleged she was raped overnight; her upper body was assessed and no new skin issues were noted; when attempted to help the Resident undress her lower body, she became emotional and frightened and it was deemed okay to stop examination as the Resident would be sent to hospital for SAR (sexual assault response) kit; all clothing remained the same as overnight; and her bedding was preserved.</p> <p>Review of nursing documentation dated August 2, 2024, at 9:50 AM, revealed Resident 1 was sent to the hospital per order via stretcher in an ambulance.</p> <p>Review of hospital documentation dated August 2, 2024, at 10:55 AM, revealed that Resident 1 presented to the emergency room for a possible rape.</p> <p>The Resident was accompanied by her caregiver (Facility NA), who stated she went into the patient's room as usual to get her ready for the day. The patient was not acting herself, complaining of pain. Resident 1 stated, Someone came into my room during the night and 'fucked' me. (profanity is out of character for this patient). When caretaker lowered the resident's blankets, her pants were at her knees. This is also out of character for this patient. Upon questioning, the resident stated that she had vaginal bleeding since the time of the assault. The resident and her sister agreed to have a SANE examination (Sexual Assault Nurse Examiner) completed.</p> <p>Review of the SANE examination revealed:</p> <ul style="list-style-type: none"> -abrasions noted to the labia (folds of protective skin located on each side of the vaginal opening) -lacerations to the mons pubis (rounded, fleshy area on the front of the pelvic bone) -bruising of the cervix (lower part of the uterus that separates the lower uterus and the vagina.) <p>The county Area on Aging and protective services were at the Resident's bedside. The state police were contacted and arrived at the hospital on August 2, 2024, at 4:10 PM, to pick up the chain of custody evidence kit.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Discharge instructions included sexual assault instructions.</p> <p>Nursing documentation dated August 2, 2024, at 8:40 PM, revealed Resident 1 returned to the facility from the hospital. Facility staff preformed a physical exam. Resident 1 had generalized discomfort to shoulder and pubic region. LPN provided Tylenol for pain management.</p> <p>Review of a facility deployment sheet (the daily nursing staff assigned by shift and by hallway) indicated that there was one LPN (Employee 5) and one NA (Employee 3 [Agency NA]) assigned to the hallway Resident 1 resided on the overnight shift on August 1 into 2, 2024.</p> <p>Review of Employee 2's witness statement dated August 2, 2024, at 7 AM, revealed It was brought to my attention during A.M. care that Resident 1 was touched by a male person, and she was in a lot of pain. I immediately went to inform the DON.</p> <p>There was no witness statement available at the time of the survey from Employee 1, the Employee who first saw the Resident 1 after the incident noted above.</p> <p>Employee 3's witness statement dated August 2, 2024 (no time indicated), stated, On first rounds, Resident 1 was taken to the bathroom. I stepped out (of the bathroom) because she wanted privacy. I helped her in and out of the wheelchair. Later, Resident 1 rang her call bell for tylenol and cough medicine. On Last rounds, I changed her in her bed. Employee 4 (Agency NA) asked if I needed help. Employee 4 changed Resident 1's roommate (nonverbal with significant cognitive impairment). When I was done with Resident 1, I went over to help Employee 4 and then we left the room.</p> <p>There was no witness statement available at the time of the survey from Employee 4.</p> <p>Employee 5's witness statement dated August 2, 2024 (no time indicated), Throughout the 11 P.M. to 7 A.M. shift, Employee 3 was mostly in the hallway. He was in patient's room once when she put on her light requesting Tylenol and cough medicine. After administering the medicine, the patient went back to sleep and remained asleep. I was on and off the hallway throughout the shift.</p> <p>Review of Employee 6's (LPN) witness statement dated August 2, 2024, (no time indicated) revealed, I did not see Resident 1 throughout the night. The Peach hall nurse aide [Employee 4] was at the nurse's station most of the shift and up and down the hall (not identified) many times. Aide on the floor [Employee 3] was observed several times from 3 AM to 7 AM at the other end of the hall with the other aide enter room during rounds and exit room together. Unsure of length of time in room but was not a long time. The statement further revealed that Employee 6 observed Employees 3 and 4 enter the Resident's room but not exiting the room, so Employee 6 was unsure of the length of time.</p> <p>Review of a Employee 7's witness statement (Registered Nurse Supervisor) date August 2, 2024 (no time indicated), revealed, Employee 3 was busy for most of the night doing his assigned tasks. Every time I saw him, he was in or around a different room.</p> <p>Review of Resident 1's witness statement dated, August 2, 2024 (no time indicated), revealed A man came into my room, pulled my pants down, pinned my arms, had sex with me.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Resident 1 on August 5, 2024, at approximately 10:30 AM, conducted in the presence of the facility social services director, a State police officer, and the surveyor, the Resident confirmed that on August 2, 2024, during the night shift, she was in bed and a male entered her room, pulled back the bed covers, got in her bed, pinned her arms down, covered her mouth with his hand, and put his [NAME] inside her. She stated that It really hurt me down there. I was really scared, I'm still scared. She stated that she still had pain in her groin area and the I don't want any men to take care of me.</p> <p>During the interview, the Resident was asked several times to describe the man. She stated that she couldn't remember and that it was dark in the room with no lights on at the time of the incident.</p> <p>Review of documentation revealed Employee 3 was the only male on duty the shift the incident occurred. He was an agency employee that had worked regularly at the facility since November 2023.</p> <p>The facility failed to ensure that Resident 1 was free from sexual abuse and psychosocial harm.</p> <p>An interview with the DON on August 5, 2024, at approximately 12:00 PM, confirmed the sexual assault and psychosocial harm occurred for Resident 1 as noted above.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 201.29(a) Resident rights</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing Services</p> <p>28 Pa. Code 201.18(1) Management</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142</p> <p>Based on a review of clinical records, policy review, and staff interviews, it was determined that the facility failed to submit a timely and thorough investigation of alleged sexual abuse to the State Survey Agency for one of four residents reviewed (Resident 1).</p> <p>Findings included:</p> <p>A review of the current facility policy, titled Abuse, neglect, mistreatment, misappropriation of resident property and exploitation prevention, revision date March 26, 2024, revealed that 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. Staff, representative representatives, 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 statements will be obtained.</p> <p>A review of Resident 1's clinical record revealed that the Resident was admitted to the facility on [DATE], with diagnoses that included atherosclerotic heart disease and diabetes. She was noted to be [AGE] years of age at the time of the survey.</p> <p>A quarterly Minimum Data Set assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated May 23, 2024, indicated that the Resident was moderately cognitively impaired, with a BIMS (brief interview for mental status - a tool to assess cognitive status) of 7.</p> <p>Review of a facility investigation report dated August 2, 2024, at 7:15 AM, revealed that on that date and time Resident 1 was about to receive morning care when she disclosed to Employee 1 (Nurse Aide [NA]) that during the night (the prior 11 PM to 7 AM shift) a man came into her room, pinned her down and fucked her, and that she was sore down there. Per Employee 1, the Resident was in bed, her brief was in place, and her pajama bottoms at her knees. Employee 1 reported this to Employee 2 (Licensed Practical Nurse [LPN]), and both then reported it to the Director of Nursing (DON). The DON attempted to do a physical assessment; however, when staff attempted, the Resident refused to have her bra removed. When staff attempted to help the Resident undress her lower body, she became guarded and started crying, stating I cannot do this. It hurts and I am frightened. The examination immediately ceased. The Resident's brief had been changed related to being soaked with urine. In an attempt to maintain evidence, the Resident's brief was kept in the bathroom, the sheets were left untouched, and her clothing was kept on Resident 1. The State Police, Physician, responsible party, and Department of Aging were notified. Resident 1 was taken to the hospital for evaluation.</p> <p>Nursing documentation dated August 2, 2024 at 9:50 AM, revealed Resident was sent to Hospital per order via stretcher Ambulance and accompanied by 2 EMTs(emergency medical technicians).</p> <p>Further review of both Resident 1's clinical records conducted during the survey ending July 6, 2024, revealed no further information regarding this incident on August 2, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Director of Nursing (DON) on August 2, 2024, at approximately 12:00 PM, she stated that all staff on duty August 2, 2024, 11 PM to 7 AM shift, were not interviewed regarding the alleged sexual assault. There was no documented evidence in the Resident's clinical record regarding the incident. The DON confirmed that the facility had not conducted an thorough investigation into the incident of potential sexual abuse, despite Resident 1's allegation and physical and mental symptoms.</p> <p>There was no documented evidence at the time of survey ending August 2, 2024, that the facility had completed an abuse investigation.</p> <p>An interview with the DON on September 21, 2023, at approximately 2:30 PM, confirmed the facility did not have documented evidence that the facility had completed an abuse investigation and assure the appropriate corrective action taken to prevent the potential for further sexual abuse of Resident 1.</p> <p>cross refer F600, F842, F943</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing Services</p> <p>28 Pa. Code 201.29(a) Resident rights</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee</p> <p>28 Pa. Code 201.18(1) Management</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142</p> <p>Based on observation, clinical record review, and staff interview, it was determined that the facility failed to timely develop and implement a person-centered care plan to meet one resident's current needs for aggressive behaviors for one of nine residents reviewed (Resident 2).</p> <p>Findings including:</p> <p>Clinical record review revealed that Resident 2 was admitted to the facility on [DATE], with diagnoses to include dementia with behavioral disturbance.</p> <p>Review of quarterly Minimum Data Set Assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated April 27, 2024, revealed that Resident 2 was severely cognitively impaired, with a BIMS score (Brief Interview for Mental Status - is a mandatory tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility) of 3, and required assistance from staff for activities of daily living.</p> <p>A review of the Resident's current plan of care initially dated July 4, 2023, did not include any reference to the Resident's physically aggressive behaviors.</p> <p>A review of a facility investigation report dated July 26, 2024, at 5:00 PM, revealed Resident 2 was taken out of the facility to go to mass and lunch on July 26, 2024, at 11:30 AM, by her son. Upon their return to the facility at 2:50 PM, the son came immediately to the nurses' station stating that his mother had wandered away. Resident 2's son was distraught and reported that he had slapped his mother in the face. When he told his mother that it was time to return to the facility, she became angry and violent, slapping her son and knocking his glasses off. The son continued, she then threw herself on the ground and would not get up, he had to drag her to the car and slap her across the face to get her to subdue.</p> <p>Nursing staff assessed the Resident and noted that the Resident had a small amount of bruising to the right side of her face, bruising to her left cheek, multiple ecchymotic areas to her right upper arm, and a skin tear to her right elbow. Nursing staff addresses the above noted areas and Resident 2 had no recollection of the event.</p> <p>The investigation conclusion indicated that Resident 2's son had not seen his mother in a while and did not have the training and or coping skills developed to deal with the situation while it was occurring.</p> <p>There was no evidence at the time of the survey that Resident 2's care plan had been updated to reflect ongoing aggressive behaviors and that the Resident's son was made aware and received any education prior to taking his mother out of the facility on a leave of absence.</p> <p>During an interview on August 5, 2024, at 12:00 PM, the Director of Nursing confirmed that the Resident's physically aggressive behaviors were not addressed on the Resident's plan of care.</p> <p>(continued on next page)</p>		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa Code 211.12 (5) Nursing Services

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to maintain complete and accurate clinical records for one of four residents reviewed (Resident 1).</p> <p>Findings include:</p> <p>A review of Resident 1's clinical record revealed that the Resident was admitted to the facility on [DATE], with diagnoses that included atherosclerotic heart disease and diabetes. She was noted to be [AGE] years of age at the time of the survey.</p> <p>A quarterly Minimum Data Set assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated May 23, 2024, indicated that the Resident was moderately cognitively impaired, with a BIMS (brief interview for mental status - a tool to assess cognitive status) of 7.</p> <p>Review of a facility investigation report dated August 2, 2024, at 7:15 AM, revealed that on that date and time Resident 1 was about to receive morning care when she disclosed to Employee 1 (Nurse Aide [NA]) that during the night (the prior 11 PM to 7 AM shift) a man came into her room, pinned her down and fucked her, and that she was sore down there. Per Employee 1, the Resident was in bed, her brief was in place, and her pajama bottoms at her knees. Employee 1 reported this to Employee 2 (Licensed Practical Nurse [LPN]), and both then reported it to the Director of Nursing (DON). The DON attempted to do a physical assessment; however, when staff attempted, the Resident refused to have her bra removed. When staff attempted to help the Resident undress her lower body, she became guarded and started crying, stating I cannot do this. It hurts and I am frightened. The examination immediately ceased. The Resident's brief had been changed related to being soaked with urine. In an attempt to maintain evidence, the Resident's brief was kept in the bathroom, the sheets were left untouched, and her clothing was kept on Resident 1. The State Police, Physician, responsible party, and Department of Aging were notified. Resident 1 was taken to the hospital for evaluation.</p> <p>Nursing documentation dated August 2, 2024, at 9:50 AM, revealed Resident sent to Hospital per order via stretcher Ambulance and accompanied by 2 EMTs(emergency medical technicians).</p> <p>There was no additional documentation regarding Resident 1's incident dated August 2, 2024.</p> <p>During an interview August 5, 2024, at 12:00 PM, the DON confirmed that Resident 1's clinical record did not contain complete and accurate documentation.</p> <p>cross refer F600, F610</p> <p>28 Pa Code 201.18(1)Management</p>		

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>26142</p> <p>Based on staff interviews and a review of employee personnel records, it was determined that the facility failed to provide abuse prevention training to agency nursing staff for two of 5 reviewed (Employees 3 and 8).</p> <p>Findings include:</p> <p>A review of agency staffing documentation, provided to the facility prior to an agency staff's first day worked at the facility noted that Employee 3 (Agency Nurse Aide) first worked at the facility November 13, 2023, and has worked steadily since.</p> <p>During an interview with Employee 8 (Agency Registered Nurse) on August 5, 2024, at 12:00 PM, he stated that he had been working at the facility for three months. Employee 8 stated that he was never trained on the facility's abuse prohibition policy prior to assuming his duties as of the interview date.</p> <p>There was no documentation that Employee 8 was trained on the facility's abuse prohibition policies and procedures as part of staff orientation and training on the prohibition of all forms of abuse, neglect, and exploitation prohibition.</p> <p>An interview on August 5, 2024, at 11:00 AM, with the facility staffing coordinator revealed that she confirms the agency nurse staff's credentials to include background check, driver's license, nursing license or certificate, and medical information prior to their first day of employment at the facility. She stated that she does not request any abuse training. She stated that the facility does rely on agency licensed nurse and nurse aide agency staff to assure adequate staffing ratios in the facility, and she could not provide evidence of abuse training for any agency currently working at the facility</p> <p>Interview with the Director of Nurses on August 5, 2024, at 12:00 PM, confirmed that agency staff are not trained on the facility's policy and procedures as part of staff orientation and training before assuming job duties.</p> <p>cross refer F610, F600</p> <p>28 Pa. Code 201.20 (b)(1) Staff development</p> <p>28 Pa. Code 201.19 (3) Personnel policies and procedures</p>		