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	11/21/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility policy, and staff interviews, it was determined the facility failed to develop and implement an individualized pain management program consistent with professional standards of practice, failed to attempt non-pharmacological interventions to alleviate pain prior to the administration of pain medication prescribed on an as needed basis, and failed to follow physician orders when administering pain medication for two residents out of 20 residents reviewed (Resident 74 and Resident CR1).Findings include: According to the US Department of Health and Human Services, Interagency Task Force, Executive Summary Draft Final Report May 6, 2021, for Pain Management Best Practices, the development of an effective pain treatment plan after proper evaluation to establish a diagnosis with measurable outcomes that focus on improvements including quality of life (QOL), improved functionality, and Activities of Daily Living (ADLs). Achieving excellence in acute and chronic pain care depends on the following: An emphasis on an individualized patient-centered approach for diagnosis and treatment of pain is essential to establishing a therapeutic alliance between patient and clinician. Acute pain can be caused by a variety of different conditions such as trauma, burn, musculoskeletal injury, neural injury, as well as pain due to surgery/procedures in the perioperative period. A multi-modal approach that includes medications, nerve blocks, physical therapy and other modalities should be considered for acute pain conditions. A multidisciplinary approach for chronic pain across various disciplines, utilizing one or more treatment modalities, is encouraged when clinically indicated to improve outcomes. A review of the facility policy labeled Pain Management last reviewed by the facility in January 2025, revealed the facility will recognize when a resident is experiencing pain, identify circumstances when pain can be anticipated, evaluate the existing cause of pain, and manage and prevent pain for residents. A clinical record review revealed Resident 74 was admitted to the facility on [DATE], with diagnoses that included spinal stenosis (abnormal narrowing of the spinal canal that results in pressure on the spinal cord or nerve roots) and unspecified open wound, of the lower left leg. An admission MDS assessment (Minimum Data Set, a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated September 16, 2025, indicated the resident was cognitively intact, with a BIMS score of 14 (Brief Interview for Mental Status a tool to assess the residents attention, orientation and ability to register and recall new information , a score of 13 to 15 indicates intact cognition). A physician's order dated December 19, 2022, directed staff to administer Resident 74 Acetaminophen 325 mg, give two tablets by mouth four times a day for primary general osteoarthritis (occurs when the cartilage that cushions the ends of the bones in the joints deteriorates causing pain). A physician's order dated March 20, 2025, directed staff to administer Acetaminophen 325 mg, one tablet every twenty-two hours as needed for pain that is mild on a pain scale rated 1 to 3. A pain scale involves the use of numbers to rate pain intensity, most often from 0 to 10, where 0 corresponds to no pain and 10 corresponds to the worst possible pain. Mild pain is typically rated 1 to 3, moderate pain 4 to 6, and severe pain 7 to 10. The March 20, 2025, order also directed that non-pharmacological interventions be attempted prior to administration, including back rub, repositioning, applying ice, turning the lights out, and one-to-one interaction, and further specified that the resident may only have one tablet in twenty-four hours due to a separate scheduled order not to exceed 3 grams in twenty-four hours. A physician's order dated July 30, 2025: Tramadol HCL 25 mg (a Schedule IV narcotic pain medication) every six hours as needed for severe pain rated 7-10. A pain scale is a tool that assigns a number from 0 (no pain) to 10 (worst possible pain) to measure pain intensity. Mild pain is typically 1-3, moderate pain 4-6, and severe pain 7-10. August 16, 2025: Tramadol HCL 50 mg every six hours as needed for moderate pain. A review of the August 2025 MAR (medication administration record) documented the following:Acetaminophen 325 mg, one tablet every twenty-two hours as needed for mild pain, was administered one time.Tramadol 25 mg was administered six times from August 1 through August 13, 2025. Four of these administrations were outside the physician-ordered pain-rating parameters, meaning the narcotic was not administered in accordance with the provider's instructions for pain rating.Medication administrations outside of ordered parameters included:August 5, 2025, at 9:45 AM: Tramadol given for a reported pain rating of 3 (severe pain order required 7-10).August 9, 2025, at 8:48 AM: Tramadol given for a pain rating of 4.August 10, 2025, at 8:51 AM: Tramadol given for a pain rating of 4.August 12, 2025, at 11:36 AM: Tramadol given for a pain rating of 4. A review of associated documentation revealed no evidence that non-pharmacological interventions were

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy and staff interviews, it was determined the facility failed to ensure that a resident's drug regimen was free of unnecessary antibiotics for one out of 20 residents sampled (Resident CR1). Findings included: A review of a facility policy labeled Antibiotic Stewardship Program last reviewed by the facility in January 2025, revealed the facility will confirm the presence of clinical symptoms of infection before collecting cultures or starting antibiotics. The policy revealed the facility will use standardized forms/checklists for urinary tract infections, and the facility will obtain cultures before starting antibiotics whenever feasible. The policy further revealed that a resident will only be started on empiric antibiotics (antibiotic use before laboratory results are available) only if the resident meets clinical criteria and appears systemically ill (fever, tachycardia, hypotension, rigors). A review of Resident CR1's clinical record revealed the resident was admitted on [DATE], with diagnoses including chronic obstructive pulmonary disorder (a lung disease that causes airway damage and breathing difficulty) and muscle weakness. A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated August 11, 2025, revealed that Resident CR 1 had intact cognition with a BIMS score of 13 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). Review of resident CR1's progress notes revealed a progress note documented on October 5, 2025, at 1:34 PM indicating the resident's family had expressed concerns about the resident's increased hallucinations (sensory experiences such as seeing, hearing or feeling something that appear real but are not present in the environment), the progress note revealed at the request of the family a urinalysis with culture and sensitivity (a laboratory test used to detect and identify bacteria or fungi in urine, A urine culture is a method to grow and identify bacteria that may be in the urine. The sensitivity test helps select the best medicine to treat the infection) to assess for possible infection) was ordered. Further review of CR1's progress notes revealed a progress note dated October 6, 2025, at 2:52PM documenting that the resident had no signs of a urinary tract infection. A progress note dated October 6, 2025, at 2:52 PM documented that the resident had no signs or symptoms of a urinary tract infection, and the physician was notified of the abnormal urinalysis results while awaiting culture and sensitivity (C&S) results. A progress note dated October 7, 2025, at 11:46 AM revealed the physician was made aware of preliminary urinary culture results and had no new orders at that time. Another progress note dated October 7, 2025, at 2:25 PM again documented that the resident was not experiencing any urinary symptoms, including no confusion. Despite the absence of urinary symptoms, a physician order dated October 8, 2025, directed initiation of Macrobid 100 mg twice daily for 5 days. Macrobid is an antibiotic used to treat urinary tract infections. A review of the urine culture and sensitivity report, resulted on October 9, 2025, at 7:16 AM, revealed the presence of two organisms:Citrobacter werkmanii, a bacterium that can cause urinary tract infections, andProteus mirabilis, a gram-negative bacterium known to cause urinary tract infections.The sensitivity results revealed that Proteus mirabilis was resistant to Macrobid, meaning Macrobid would not effectively treat the infection. A progress note dated October 9, 2025, at 3:22 PM documented that the provider reviewed the culture and sensitivity results and discontinued Macrobid. A new order was entered for Bactrim DS, an antibiotic active against the identified organism, for 10 days. A review of Resident CR1's clinical record revealed that three Urinary Change Forms, documented on October 7, 2025, at 2:38 PM, October 8, 2025, at 10:32 PM, and October 9, 2025, at 2:40 PM, all indicated no changes in the resident's condition that would justify initiating Macrobid prior to receiving culture results. A review of the October 2025 Medication Administration Record revealed the resident received two doses of Macrobid before laboratory confirmation of an infection requiring antibiotic therapy and before the organism's resistance to Macrobid was known. The clinical record did not contain any documentation of urinary symptoms that would meet clinical criteria for initiating empiric antibiotic therapy (use of antibiotics before laboratory results are known). The facility was unable to provide documentation of McGeer's criteria, a standardized set of infection surveillance criteria used in long-term care settings to determine when an infection is present. These criteria require documented urinary symptoms to justify antibiotic treatment, and no such symptoms were documented. During an interview with the Director of Nursing (DON) on November 20, 2025, at 1:15 PM, the DON reviewed the clinical findings with the surveyor. The DON acknowledged the documented sequence of

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to ensure that laboratory and diagnostic test results were promptly provided to the ordering physician for one of twenty sampled residents (Resident CR1). Findings include: A review of resident CR 1's record revealed the resident was admitted to the facility on [DATE], with diagnoses to include chronic obstructive pulmonary disorder (a condition caused by damage to the airways or other parts of the lung) and muscle weakness. A review of a quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated August 11, 2025, revealed that Resident CR 1 had intact cognition with a BIMS score of 13 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). A nursing progress note dated October 9, 2025, at 8:03 AM documented a phone call from the resident's family reporting the resident was experiencing uncontrolled head and neck pain following a fall within the facility. A cervical spine x-ray (a diagnostic test that uses radiographs to visualize the bones of the neck) was completed on October 9, 2025, at 11:24 AM. The x-ray report identified an apparent right-lung infiltrate, which is an abnormal substance or fluid in lung tissue that can occur for various reasons, including infection. The report recommended clinical correlation and a follow-up chest x-ray. A review of Resident CR1's clinical record revealed no documentation that the physician was notified of the abnormal x-ray findings. The clinical record also revealed no documentation that the recommended follow-up chest x-ray had been completed. During an interview on November 21, 2025, at approximately 12:00 PM, the Director of Nursing (DON) reviewed the above findings with the surveyor. The DON did not provide an explanation for the absence of documentation showing the physician had been notified of the abnormal results or had reviewed the x-ray findings. The DON confirmed that it is the facility's responsibility to ensure the physician is promptly provided with laboratory and diagnostic test results. 28 Pa Code 211.2 (d)(3) Medical director. 28 Pa Code 211.12 (d)(3) Nursing services.