

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 04/05/2024
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929</p> <p>Based on review of clinical records and staff interview, it was determined that the facility failed to timely notify the resident's interested representative of a change in condition, a significant weight loss, for one resident out of 18 sampled (Resident 26).</p> <p>Findings include:</p> <p>A review of the clinical record revealed that Resident 26 was admitted to the facility on [DATE], with diagnoses which included Parkinson's disease.</p> <p>A review of the resident's recorded monthly weights revealed that on June 3, 2023, the resident's weight was noted as 149 lbs. The resident's recorded monthly weight dated December 3, 2023, revealed that the resident's weight decreased to 130.2 lbs. The resident lost 18.4 lbs, a significant weight loss of 12.4% loss of body weight, in six months.</p> <p>A dietary note dated December 20, 2023, indicated that the resident's weight had decreased to 130.2 lbs and that the resident's attending physician was notified.</p> <p>The resident's significant weight loss was identified on December 3, 2023, but there was no documented evidence that the resident's representative was informed.</p> <p>An interview with the Nursing Home Administrator on April 4, 2024, at approximately 2:00 PM confirmed the facility failed to timely notify the resident's representative of the resident's significant weight loss.</p> <p>28 Pa Code 211.12 (d)(3) Nursing services</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 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** 39929</p> <p>Based on a review of clinical records and staff interview, it was determined that the facility failed to address a resident's significant weight loss on the resident's comprehensive care plan for one resident out of 18 residents sampled (Resident 26).</p> <p>Findings include:</p> <p>A review of the clinical record revealed that Resident 26 was admitted to the facility on [DATE], with a diagnosis of Parkinson's disease.</p> <p>A review of the resident's recorded monthly weights revealed that on June 3, 2023, the resident's weight was noted as 149 lbs. The resident's recorded monthly weight dated December 3, 2023, revealed that the resident's weight decreased to 130.2 lbs. The resident lost 18.4 lbs, a significant weight loss of 12.4% loss of body weight, in six months.</p> <p>Review of Resident 26's care plan revealed that as of the end of survey April 5, 2024, the resident's weight loss and decline in nutritional parameters was not included on the resident's care plan and there was no plan identified to maintain adequate nutritional status for Resident 26.</p> <p>During an interview with the Nursing Home Administrator and Director of Nursing on April 4, 2024, at approximately 10:35 a.m., confirmed that the resident's comprehensive care plan did not address Resident 24's weight loss and current nutritional needs.</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services</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>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460</p> <p>Based on a review of clinical records, observations and staff interviews it was determined that the facility failed to timely identify, assess and treat a facility acquired pressure sore for one resident (Resident 24) and failed to consistently monitor a resident's skin integrity related to the use of a therapeutic device to prevent a facility acquired pressure sore for one resident out of 18 sampled (Resident 13).</p> <p>Findings included:</p> <p>A review of Resident 24's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses to have included hypertension [high pressure in the arteries (vessels that carry blood from the heart to the rest of the body)], type II diabetes (is a condition results from insufficient production of insulin, causing high blood sugar), and congestive heart failure [is a progressive heart disease that affects pumping action of the heart muscles that causes fatigue, and shortness of breath].</p> <p>A review of the resident's plan of care for skin integrity dated May 21, 2020, and last revised on March 9, 2024, identified that Resident 24 had the potential risk for skin impairments related to decreased mobility, PVD, and bowel incontinence with a goal for the resident's skin to remain clean and intact. Planned interventions were to assist resident with turning and repositioning, keep skin clean and dry, moisture barrier cream after each incontinent episode, and follow facility protocols for treatment of injury.</p> <p>A nursing progress note completed by Employee 3, a licensed practical nurse, and dated March 9, 2024, at 1:54 a.m., indicated that she was made aware of an open area in the resident's right buttock. The area was noted as 3.0 centimeters (cm) x 2.0 cm and was cleansed with normal saline solution (NSS) and a clean dry dressing was put in place. Peri care (bathing the genitalia and surrounding area) provided, and the resident was repositioned for comfort. Registered nurse (RN) Supervisor made aware. No new orders at this time. Will continue to monitor.</p> <p>A review of a facility provided incident report investigation, completed by Employee 3, and dated March 9, 2024, at 7:04 a.m., regarding the above open area revealed the resident was unable to give a description of the incident, and the predisposing physiological factors included that the resident was incontinent.</p> <p>A review of an employee witness statement completed by Employee 4, a nurse aide (NA), and dated March 9, 2024, no time noted, revealed that while changing Resident 24 she noticed that there was an open area on his right buttocks, near the anus and that nursing was notified.</p> <p>A nurse progress note completed by Employee 5, a RN, dated March 9, 2024, at 7:12 a.m., revealed that night aides reported to RN {Employee 5} that patient had an open area to his buttock. Employee 5 noted wound appears days old and cleaned with saline and covered with Mepilex border (a soft foam absorbent dressing). Patient is not in any pain when asked.</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>Resident 24's physician's orders that were noted by the Assistant Director of Nursing (ADON), and dated March 11, 2024, at 2:28 p.m., revealed new orders for zinc to the right buttocks every shift until healed.</p> <p>A review of the resident's treatment administration record [(TAR) is an electronic record of physician prescribed treatments administered/performed by licensed nursing staff] dated March 2024, revealed that there was no documented evidence that a treatment was applied or implemented upon the discovery of a new skin impairment to the right buttocks noted on March 9, 2024. Nursing solely documented cleansing of the area and applying a soft dressing.</p> <p>The facility was not able to provide documented evidence that a RN completed a thorough assessment to Resident 24's facility acquired skin impairment to include a description of the area and surrounding skin or that the RN timely obtained orders for treatment to promote healing and prevent further decline.</p> <p>At the time of the survey the facility was unable to provide documented evidence that the resident's pressure sore was consistently monitored for healing status.</p> <p>During an interview with the ADON and in the presence of the Nursing Home Administrator (NHA) on March 5, 2024, at 11:15 a.m., confirmed that the facility could not provide documented evidence that Resident 24's skin impairment to the right buttocks was timely and thoroughly assessed by a RN, and confirmed that there was no documented evidence that a treatment was timely implemented and performed. The ADON also noted the absence of wound tracking and monitoring of the resident's right buttock pressure sore by facility nursing staff.</p> <p>Review of Resident 13's clinical record revealed admission to the facility on [DATE], with diagnoses to include aftercare for left hip fracture and dementia.</p> <p>Review of Resident 13's hospital discharge record dated February 20, 2024, revealed that the resident had surgical repair of the left hip and had a left knee immobilizer in place. According to discharge orders, the immobilizer was to remain in place except when resident on CPM (continuous passive motion) machine and was non-weight bearing on left leg for at least 6 weeks and excoriation/redness on her sacrum that required treatment.</p> <p>Review of Resident 13's admission physician orders dated February 20, 2024, indicated that the resident's left leg was to be elevated, a low air loss mattress was applied to the bed, skin checks were to be performed with showers which were scheduled on Thursdays in the evening, and apply skin prep to bilateral heels every shift for skin prevention.</p> <p>Review of Resident 13's Braden Scale Assessment (a standardized, evidence -based assessment tool commonly used in health care to assess and document a patient's risk for developing pressure injuries) dated February 20, 2024, revealed that Resident 13 was at moderate risk, scoring a 14 (total score of 13-14 indicates the resident was at moderate risk, 10-12 indicates high risk).</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>A review of Resident 131's care plan, initially dated February 20, 2024, revealed that the resident was identified as having potential for impairment to skin integrity related decreased mobility. Planned interventions were to avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short, educate resident/family/caregivers of causative factors and measures to prevent skin injury, encourage good nutrition and hydration, follow facility protocol for treatment of injury, identify/document potential causative factors and eliminate/resolve where possible, use lotion on dry skin as ordered, low air loss mattress to bed, administer medications as ordered, use caution during transfers, weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate (drainage) and any other notable changes or observations, and report abnormalities, failure to heal, signs/symptoms of infection or maceration to physician.</p> <p>Review of a progress note completed by orthopedic doctor dated March 6, 2024, indicated that Resident 13 had acquired a skin pressure wound at posterior left cast {calf} secondary to knee immobilizer and small skin wound at medial right calf. Recommendations included daily dressing changes to wounds on left and right calf wounds with betadine and bulky dry sterile dressing. Knee immobilizer for bed to chair transfers only, no immobilizer in bed.</p> <p>Review of Resident 13's wound assessment completed by facility consultant wound physician dated March 14, 2024, revealed that the left calf wound measured 2.5 cm x 3.4 cm x 0.1 cm, included 1-24% granulation (healthy) tissue, and 75-99% slough (dead tissue). Date that the wound was acquired as undetermined. Treatment recommendations were to cleanse the calf ulcer with normal saline solution, apply Santyl, and a dry dressing daily and as needed.</p> <p>Review of weekly wound evaluations completed by wound care physician dated April 4, 2024, revealed that the left calf wound measured 1.5 cm x 0.8 cm x 0.1 cm and was improving without complications. No change in treatment recommendations.</p> <p>There was no evidence that the facility monitored the resident's left leg during application and/or removal of the left knee immobilizer to observe skin integrity and timely identify skin breakdown.</p> <p>Observation of Resident 13's left calf wound on April 5, 2024, at approximately 11 AM revealed that the area showed signs of healing, no drainage or signs of infection were observed</p> <p>Interview with the Director of Nursing on March 5, 2024, at approximately 2:30 PM confirmed that there was no evidence the facility consistently monitored Resident 13's skin during the application/removal of her left knee immobilizer to timely identify skin breakdown.</p> <p>28 Pa. Code: 211.12 (c)(d)(1)(3)(5) Nursing Services</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944</p> <p>Based on clinical record review, observation, resident, and staff interview it was determined that the facility failed to provide restorative nursing services and devices to maintain mobility/range of motion to prevent further limitations for one of 18 sampled residents (Resident 34).</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 34 was admitted to the facility on [DATE], with diagnoses that included difficulty in walking, abnormal posture, osteoarthritis (long-term degenerative joint condition in which the tissue and parts of the joint deteriorates causing pain and stiffness) and muscle weakness.</p> <p>Review of Resident 34's Physical Therapy Discharge Summary dated February 27, 2023, at 8:53 AM revealed that the resident highest practical level of functioning was achieved. The resident was referred for a restorative nursing program (RNP) upon discharge from PT. The RNP recommendations included transfers PCC (point click care an electronic health record) documentation sit to stand minimum to moderate assist of one staff with instructions of pulling from hall rail and transition to rollator walker, verbal cues for nose over toes. Ambulation PCC documentation ambulate with rollator walker up to 60 feet with instructions of contact guard assist of one staff.</p> <p>Review of current physician's orders dated May 4, 2023, at 2:35 PM, indicated ankle stirrup (a brace applied to the ankle to allow for best performance with the protection for return to activity following an injury to prevent reinjury) to left lower extremity when out of bed.</p> <p>A quarterly Minimum Data Set assessment ([MDS] a standardized assessment completed at specific intervals to identify specific resident care needs) dated January 26, 2024, indicated that the resident was cognitively intact and required extensive assistance from staff for most activities of daily living.</p> <p>Review of the clinical record titled Kardex dated April 2, 2024, revealed under safety that staff were to apply the ankle stirrup to resident's left lower extremity when out of bed.</p> <p>Further review of the clinical record revealed no documented evidence that a restorative nursing program was developed and implemented to maintain Resident 34's level of function upon discharge from physical therapy or that the stirrup support device was being applied to the resident's left ankle.</p> <p>Observations on April 2, 2024, at 9:53 AM and again, at 12:42 PM, revealed that the resident was seated in a recliner chair without the stirrup ankle support brace in place. Observation revealed a sign located at the head of the resident's bed stating, Staff reminder: put air cast on right foot/ankle every morning.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with Resident 34 on April 2, 2024, at 9:53 AM revealed that staff do not apply this ankle support to her right ankle. The resident stated that staff become frustrated and say it is a pain to put on so they just do not put it on, and she knows that she should probably complain about it because it is only going to further hurt her ankle, but she doesn't say anything. The resident confirmed that the device should be applied to her right ankle. The resident voiced concerns that she was not provided with a RNP since being discharged from PT and was worried that she will never walk again.</p> <p>Interview with the Director of Nursing (DON) on April 3, 2024, at 9:22 AM confirmed the physician order for left ankle stirrup was not correct and the order was changed to the right extremity.</p> <p>Observation on April 5, 2024, at 9:16 AM revealed that Resident 34 was sitting in her recliner chair without the stirrup ankle support brace in place.</p> <p>Interview with Employee 2, Director of Therapy, on April 5, 2024, at 12:14 PM revealed that the resident was to use the stirrup ankle support device to stabilize her right ankle when ambulating for transfers and confirmed that the facility failed to provide restorative nursing services to this resident according to discharge physical therapy recommendations on February 27, 2023.</p> <p>Interview with the DON and Nursing Home Administrator (NHA) on April 5, 2024, at 1:15 PM confirmed that the RNP was not implemented as recommended by physical therapy to maintain this resident's current level of function and the resident's support device was not being applied by staff.</p> <p>28 Pa. Code: 211.5(f) Medical records</p> <p>28 Pa Code 211.12 (c)(d)(3)(5) Nursing services</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944</p> <p>Based on observations and a review of clinical records and select facility policy and staff interview it was determined that the facility failed to consistently administer oxygen as ordered and maintain sanitary oxygen delivery systems for one out of five sampled residents (Resident 85).</p> <p>Findings included:</p> <p>According to the American Thoracic Society, oxygen is a medication that requires a prescription from a healthcare provider. The provider will prescribe your oxygen at a specific flow rate and a specific number of hours per day. It is very important that oxygen is used as prescribed. Using too little oxygen may put a strain on the heart and brain, causing heart failure, fatigue, or memory loss. Using too much oxygen can also be a problem. For some patients, using too much oxygen can cause them to slow their breathing to dangerously low levels. It is important to wear oxygen as your provider ordered it. If the patient starts to experience headaches, confusion, or increased sleepiness after using supplemental oxygen, the patient may be getting too much.</p> <p>Review of a facility policy entitled Oxygen Administration and Supply (no policy review date provided) indicated that oxygen will be available to residents with a physician's order requiring it. Disposable humidifiers, tubing, cannula, or mask will be changed weekly by 11:00 PM to 7:00 AM shift and all equipment will be dated and documented. The cannula or mask will be kept in a plastic bag on top of the concentrator (bedside machine that concentrates ambient air to supply an oxygen-rich gas stream) or tank when not in use, the bag will be changed with the equipment.</p> <p>A review of clinical record revealed Resident 85 was admitted to the facility on [DATE], with diagnoses to include chronic obstructive pulmonary disease ([COPD] chronic obstructive pulmonary disease- chronic inflammatory lung disease that causes obstructed airflow from the lungs) and acute and chronic respiratory failure with hypoxia (lung condition where organs have inadequate oxygen supply due to fluid buildup in the lungs).</p> <p>Current physician orders dated January 3, 2024, at 5:50 PM revealed continuous oxygen therapy at three liters per minute via nasal cannula, every shift for COPD and staff were to change oxygen set-up nasal cannula/humidifier every Saturday, every night shift every Saturday for COPD oxygen dependent.</p> <p>An observation on April 2, 2024, at 10:09 AM and 1:53 PM revealed that the resident was receiving oxygen at three liters/minute via nasal cannula. The oxygen set-up nasal cannula tubing was not dated according to facility policy.</p> <p>An observation on April 5, 2024, at 9:16 AM revealed Resident 85 was seated in wheelchair sleeping without nasal cannula on delivering continuous oxygen as ordered. The oxygen concentrator was turned on and the nasal cannula was located on bed next to the resident under three blankets. Employee 1, Certified Nurse Aide (CNA) confirmed this observation and that the resident was not receiving the oxygen as ordered</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460</p> <p>Based on review of clinical records and select facility policy, observations, and staff interview, it was determined that the facility failed to maintain infection control practices to prevent spread of infection for three of 12 sampled residents (Resident 70, 75, and 24).</p> <p>Findings include:</p> <p>According to the Centers for Disease Control (CDC) Enhanced Barrier Precautions (EBP) guidance focus on gown and glove use and not other important infection control measures for prevention of multi-drug resistant organisms (MDRO). EBP are recommended for residents with any of the following: infection or colonization with a MDRO, a wound, or indwelling medical device, even if the resident is not known to be infected or colonized with a MDRO.</p> <p>Review of a facility policy entitled Irrigation Solutions (no policy review date noted) indicated that irrigation solutions will be stored, used, and destroyed in accordance with directions on the container label. Irrigation solution containers must be labeled immediately upon opening and must contain the date and time the container was opened. Unused irrigation solutions must be disposed of within 72 hours of opening the container.</p> <p>A review of the clinical record revealed that Resident 75 was admitted to the facility on [DATE], with diagnoses that include urinary tract infection ([UTI]) an infection of the urinary system which includes the kidney, bladder, or urethra), stage three pressure ulcers (characterized by full-thickness skin loss, subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough (yellow, tan, gray, green or brown) may be present but does not obscure the depth of tissue loss. May include undermining and tunneling) of the right and left buttock and unstageable pressure ulcers (full thickness tissue loss in which the base of the ulcer is covered by slough and or eschar [tan, brown or black] in the wound bed) of the right and left buttock.</p> <p>A physician order dated November 17, 2022, at 6:10 PM indicated the insertion of an indwelling catheter to gravity drainage (closed sterile system with a catheter and retention balloon that is inserted into the urethra or suprapubically to allow for bladder drainage) 18 Fr (French size, which is based upon measurement of the external diameter of the catheter tube) 10 cc (cubic centimeter, milliliter (ml) a measurement of volume in the metric system) every shift.</p> <p>A progress notes dated February 16, 2024, at 12:21 PM revealed that Resident 75 was complaining of discomfort with urination, nausea, vomiting, and gross hematuria (large amount of blood in urine). The resident was afebrile, 97.8 degrees Fahrenheit, pulse oximetry (saturated level of red blood cells that carry oxygen in blood, normal range 92-100%) 88% on room air, oxygen therapy applied at 2 liters per minute via nasal cannula, blood pressure 130/82. The resident was transferred to the emergency department.</p> <p>Blood culture results dated February 18, 2024, at 9:29 AM revealed the presence of Serratia marcescens (species of rod-shaped gram-negative bacteria anaerobe and an opportunistic nosocomial [originating in a health care setting] pathogen in humans) organism growth.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of urine culture and sensitivity results dated February 19, 2024, at 7:22 AM revealed a colony count of organisms Serratia marcescens 80,000 - 90,000 colony (cl) per milliliter (ml) and proteus-mirabilis 10,000-20,000 col/ml.</p> <p>A review of progress notes dated February 23, 2024, at 5:51 AM revealed the resident was readmitted to the facility status post septic shock and UTI. The resident had a skin evaluation completed with a noted chronic stage 4 pressure ulcers to right and left buttocks and currently has a 18 Fr/10 cc foley catheter in place. The resident was incontinent of bowel and dependent on staff for dressing, grooming, oral care, and repositioning. Transfers with a Hoyer lift (mechanical device used for transferring).</p> <p>An observation on April 2, 2024, at 9:03 AM revealed no evidence of EBP implemented for his pressure ulcer and indwelling catheter.</p> <p>A review of the clinical record revealed that Resident 70 was admitted to the facility on [DATE], with diagnoses that include Diabetes Mellitus ([DM] a metabolic disorder in which the body has high sugar levels for prolonged periods of time) and retention of urine (condition where your bladder doesn't empty all the way or at all when you urinate).</p> <p>A physician order dated November 17, 2022, at 6:10 PM was noted for insertion of an indwelling catheter to gravity drainage 18 Fr 30 cc every shift.</p> <p>A physician order dated March 21, 2024, at 10:51 AM was noted to cleanse a left gluteal fold abrasion with normal saline solution (NSS), pat dry, apply Medi honey and bordered dressing every day and evening shift for abrasion and as needed for soiled/dislodgement.</p> <p>An observation on April 2, 2024, at 9:49 AM and again on April 3, 2024, at 10:00 AM revealed an opened bottle of normal saline solution on the resident's dresser without a date or time that it was initially opened. At the end of the survey on April 5, 2024, at 9:16 AM the same bottle remained on the resident's dresser without a date or time that it was opened according to facility policy. Employee 1 CNA confirmed this observation at that time.</p> <p>There was no evidence the facility implemented EBP for his wound and indwelling catheter.</p> <p>A review of Resident 14's clinical record revealed that she was admitted to the facility on [DATE], with diagnoses that included Guillain Barre Syndrome [is a disorder of the immune system where the nerves are attacked by immune cells that causes weakness and tingling in arms and legs], chronic stage 4 pressure ulcers [the wound penetrates all three layers of skin, exposing muscles, tendons and bones in your musculoskeletal system] to the sacrum [is a large, triangular bone at the base of the spine] and right buttocks, suprapubic indwelling catheter [is a hollow flexible tube that is used to drain urine from the bladder], and colostomy [is an opening in the belly (abdominal wall) that's made during surgery. It's usually needed because a problem is causing the colon to not work properly, or a disease is affecting a part of the colon and it needs to be removed].</p> <p>A physician orders dated September 21, 2023, was noted for a suprapubic indwelling catheter to gravity drainage 20 Fr/30 cc every shift and an order for colostomy care every shift and as needed (PRN).</p> <p>(continued on next page)</p>		

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 04/05/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation of Resident 24's room entrance on April 2, 2024, at 10:05 a.m., revealed that there were no enhanced barrier precautions (EBP) in place due to the resident requiring a suprapubic catheter, colostomy, and chronic pressure ulcers.</p> <p>Observations on April 3, 2024, at 9:45 am, and again on April 4, 2024, at 10:35 a.m., revealed no indication that the facility implemented EBP required for Resident 24.</p> <p>During an interview with the Director of Nursing (DON), and in the presence of the Nursing Home Administrator (NHA) on April 5, 2024, at 9:30 a.m., confirmed that the facility failed to identify the need and implement EBP for residents that required enhanced barrier precautions due to requiring external devices for management of chronic conditions and at higher risks for development of infections.</p> <p>28 Pa. Code 211.10(a)(c)(d) Resident care policies</p> <p>28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services</p>		