

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 02/14/2025
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 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>39929</p> <p>Based on a review of facility policy, the minutes from facility Resident Council meetings, and grievances lodged with the facility, and resident and staff interviews, it was determined the facility failed to put forth sufficient efforts to promptly resolve continued resident complaints and grievances expressed during Resident Council meetings and verbal grievances, including those voiced by six of six residents attending a resident group meeting (Residents 27, 69, 63, 2, 15, and 18) and failed to keep the residents apprised of the status of the facility's decisions and efforts toward grievance resolution.</p> <p>Findings include:</p> <p>A review of the facility's Grievance Policy last revised on August 2021 indicated the residents', families, and their representatives have the right to voice grievances concerning care and treatment, behavior of staff or other residents or any concerns regarding their stay.</p> <p>A review of the Minutes from Resident Council meetings dated November 2024, December 2024, and January 2025 revealed repeated concerns from residents that fresh water was not consistently being provided daily.</p> <p>Despite these ongoing concerns, there was no documented evidence of corrective actions taken to address these issues between November 2024 and January 2025.</p> <p>A group meeting conducted on February 12, 2025, at 10:30 a.m. with six residents (Residents 27, 69, 63, 2, 15, and 18) revealed unanimous reports the facility failed to address their complaints regarding the inconsistent delivery of fresh water.</p> <p>The facility was unable to provide documented evidence that efforts had been made to resolve resident complaints concerning fresh water delivery as of the survey ending February 14, 2025, that had been repeatedly brought up during resident council meeting.</p> <p>During an interview on February 14, 2025, at 9:10 a.m., the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed the absence of documented actions addressing grievances raised during Resident Council meetings or verbal complaints.</p> <p>28 Pa. Code 201.18 (e)(1)(4) Management</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>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** 43944</p> <p>Based on review of clinical records, the facility's abuse prohibition policy, and select investigative reports, and interviews with staff and residents, it was determined the facility failed to ensure that a resident was free from neglect by not utilizing a mechanical lift as planned to ensure safety and prevent major injury, fracture of the right femoral neck, for one resident, (Resident 5), out of 18 sampled residents reviewed for abuse prohibition.</p> <p>Findings included:</p> <p>Review of the facility's policy entitled Abuse, Neglect, Mistreatment, Misappropriation of Resident Property and Exploitation Prevention last reviewed by the facility January 2025, indicated that abuse, neglect, misappropriation of resident property, and exploitation of residents would 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 5's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including cerebral palsy (CP a group of neurological disorders that appear in infancy or early childhood and permanently affect body movement and muscle coordination and is caused by damage to or abnormalities inside the developing brain that disrupt the brain's ability to control movement and maintain posture and balance), dysphagia (difficulty swallowing), contractures (shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement) to the right elbow and right and left hand, and cerebral infarction (occurs when the blood supply to part of the brain is blocked or reduced and prevents brain tissue from getting oxygen and nutrients resulting in brain cells dying).</p> <p>Resident 5's comprehensive person-centered plan of care was initiated on June 26, 2020, indicated that the resident required assistance with ADLs (activities of daily living) related to cerebral palsy, decreased mobility, and hemiplegia with a resident goal to participate at the highest level of function. Planned interventions for the resident to meet her goals included to utilize a Hoyer lift (mechanical device designed to lift/transfer individuals that have limited mobility in a safe manner and reduce injuries) for all transfers.</p> <p>Review of Resident 5's Annual MDS (Minimum Data Set - a federally mandated standardized assessment process conducted periodically to plan resident care) assessment dated [DATE], section C Cognitive Patterns revealed the resident had a BIMS score (Brief Interview for Mental Status a tool used to evaluate cognitive impairment and assist with dementia diagnosis) of 12, which indicated the resident had moderate cognitive impairment.</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>Additionally, the annual MDS was coded that the resident had functional limitations in range of motion to the upper extremity (shoulder, elbow, wrist, hand) on one side and lower extremity (hip, knee, ankle, foot) to both sides. The resident was dependent on staff for toileting, dependent on staff for sit to stand (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed), dependent with bed-to-chair transfer (the ability to transfer to and from a bed to a chair or wheelchair), dependent with toilet transfers (the ability to get on and off a toilet or commode).</p> <p>On January 26, 2025, at approximately 8:30 PM, Employee 1 (an agency Nurse Aide) and Employee 2 (another agency Nurse Aide) were providing evening care to Resident 5. A witness statement from Employee 2 indicated that while performing PM care, the resident began complaining of pain in her right arm. As Employee 2 removed the resident's shirt and bra, Resident 5 began yelling in pain. Concerned, Employee 2 alerted Employee 1 and the nurse supervisor.</p> <p>A review of witness statements from agency Nurse Aides (NAs) Employee 1 and Employee 2, both dated January 26, 2025, at 8:30 PM, did not indicate any acknowledgment of a fall or improper transfer at that time. Employee 1 documented that the incident was unwitnessed but noted that before the incident, Resident 5 was in her chair, crying, and had been uncomfortable throughout the day. Employee 2 reported that during PM care, Resident 5 complained of pain in her right arm, which intensified when her shirt and bra were removed. Employee 2 also documented that she called Employee 1 into the room to assess the situation and indicated both employees ultimately transferred the resident using the Hoyer lift at that time.</p> <p>A review of Resident 5's clinical record revealed that a Change in Condition Evaluation form was completed by Employee 3, a Registered Nurse (RN) Supervisor, on January 26, 2025, at 9:00 PM, it noted that Resident 5 exhibited pain with movement, vocalized distress (moaning, crying out, grimacing), and had localized swelling and bruising over her right shoulder and elbow. Removing her shirt and putting on night shirt caused discomfort, but she was able to perform full range of motion (ROM - the extent or limit to which a part of the body can be moved around a joint or a fixed point; the totality of movement a joint can do).</p> <p>Despite these symptoms, staff failed to immediately identify the cause of a potential serious injury. The nurse noted no history of a recent fall, but musculoskeletal pain was documented.</p> <p>A review of a witness statement for an injury of unknown origin completed by the DON on behalf of Resident 5 (hand contractures limited the resident's ability to write her own statement) on January 27, 2025, at approximately 8:00 AM, related to sustaining an injury to RUE. When asked if an incident happened while staff were transferring her from the wheelchair to bed on Sunday evening January 26, 2025, Resident 5 shook her head up and down and stated yes. When asked if staff used the Hoyer lift to transfer her from the wheelchair to bed, Resident shook her head from side to side and stated no. When asked if her RUE hurt earlier in the day on Sunday January 26, 2025, Resident 5 shook her head side to side, indicating no.</p> <p>A nurse's progress note dated January 27, 2025, at 8:09 AM, indicated that Resident 5's Responsible Party (RP) was notified of her increased pain and swelling. A physician's order for an x-ray was obtained at 10:21 AM. The mobile x-ray results, received at 2:09 PM, confirmed a mildly impacted fracture of the right humeral neck (the upper part of the right arm bone has broken near the shoulder and the broken pieces have been pushed into each other).</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>Further review of the hospital ED (emergency department) visit summary dated January 27, 2025, at 8:39 PM, indicated a fracture of humerus and aftercare instruction included to wear a sling for support, comfort, and protection, Acetaminophen (Tylenol Extra Strength - pain relieving medication) 650 - 1000 milligrams (mg) every six hours for pain, and follow up with orthopedics.</p> <p>The facility's internal investigation, completed by the Director of Nursing (DON) on January 27, 2025, at 8:10 AM revealed that during the evening shift on January 26, 2025, staff failed to use the Hoyer lift as required to transfer Resident 5 from her wheelchair to her bed. Witness statements obtained from Resident 5 (BIMS of 12, indicating moderate cognitive impairment) and her roommate, Resident 81 (BIMS of 15, indicating cognitive intactness), stated the mechanical lift was not used during the evening transfer. Resident 81 reported hearing Resident 5 let out a blood-curdling scream and noted she did not see the Hoyer lift present in the room at the time of transfer. Additionally, Resident 5 confirmed that staff did not use the Hoyer lift when transferring her that evening.</p> <p>A review of facility provided documents entitled Agency Staff Training Sign-Off revealed A review of facility-provided documents titled Agency Staff Training Sign-Off revealed that Employee 1 completed training and signed the document on October 13, 2024, and Employee 2 signed on September 17, 2024. By signing these documents, both employees acknowledged that they had reviewed and received a copy of the facility's handbook, which included the facility's abuse and neglect policy. The signatures further confirmed that they understood and agreed to adhere to all facility policies, procedures, and guidelines.</p> <p>Additionally, both employees acknowledged they had completed training and were deemed proficient to perform all assigned tasks, including proper transfer techniques. A review of Employee 1 and Employee 2's agency onboarding and orientation documents further indicated that upon hire, both employees were trained and oriented to the proper use of Hoyer lifts for resident transfers. Employee 1 completed this training on August 29, 2023, at 8:45 PM, and Employee 2 completed training on October 19, 2023, at 10:38 AM</p> <p>Despite this documented training and acknowledgment of competency, the facility's internal investigation confirmed that Employee 1 and Employee 2 failed to adhere to established protocols by not using the required Hoyer lift to transfer Resident 5 on January 26, 2025. This failure directly violated the resident's care plan and placed the resident at significant risk, resulting in an impacted fracture of the right humerus.</p> <p>During the on-site survey conducted on February 13, 2025, the facility attempted to contact Employee 1 and Employee 2 via phone to gather additional details regarding the incident. However, neither Employee 1 nor Employee 2 returned the calls, and no further clarification was obtained from them regarding the improper transfer.</p> <p>This confirms that Employee 1 and Employee 2 were aware of proper procedures but neglected to follow them, directly leading to serious harm to Resident 5.</p> <p>During an interview conducted on February 13, 2025, at 10:37 AM, the DON confirmed that based on interviews with Resident 5 and Resident 81, staff failed to use the required Hoyer lift during the January 26, 2025, evening transfer. This improper transfer resulted in a serious injury, a displaced, impacted fracture of the right humerus.</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>The facility failed to assure that all NAs consistently utilized the required transfer device, a Hoyer lift, to safely transfer Resident 5 that resulted in a serious injury to her right upper arm, a fracture.</p> <p>An interview with the DON on February 13, 2025, at 10:37 AM, revealed that based on interviews with Resident 5 and Resident 81, the DON concluded that staff did not utilize the required Hoyer lift to transfer Resident 5 from her wheelchair to bed.</p> <p>Additionally, the DON confirmed that Employee 1 and Employee 2 neglected to fulfill duties required to safely render care to Resident 5 that resulted in a serious injury, an impacted fracture of the right humerus, and increased discomfort and pain.</p> <p>28 Pa. Code 201.18 (e)(1) Management</p> <p>28 Pa. Code 201.29 (a) Resident Rights</p> <p>28 Pa. Code 211.12 (d)(5) Nursing Services</p>

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460</p> <p>interview, it was determined the facility failed to implement procedures to identify and prevent potential misappropriation of resident property, narcotic medications, for one resident out of 18 residents sampled (Resident 16).</p> <p>Findings include:</p> <p>A review of the facility policy for Abuse Protection, reviewed by the facility February 2024 revealed, it is the policy of the facility that act of physical, verbal, psychological, and financial abuse directed against residents are absolutely prohibited. The policy ensures each resident has the right to be free from verbal, sexual, physical, mental abuse and misappropriation of property.</p> <p>A review of the clinical record revealed Resident 16 was admitted to the facility on [DATE], with diagnoses with diagnoses including multiple rib fractures on the right side, periprosthetic fracture around internal prosthetic right hip joint (fracture that occurs around an implanted orthopedic prosthesis), and dysphagia (difficulty swallowing).</p> <p>The resident had a current physician order dated November 11, 2024, for tramadol HCL (opioid used to treat moderate to moderately severe chronic pain in adults) 50mg by mouth at bedtime for chronic pain.</p> <p>A review of a controlled drug packing slip revealed that the pharmacy dispensed 30 tramadol HCL 50mg tablets to the facility on [DATE], for administration to Resident 16 (once dispensed medications are the property of the resident). The medication card containing the 30 tramadol 50 mg tablets as well as the controlled drug sign-out sheet went missing on January 27, 2025, the same day.</p> <p>A review of a facility investigation dated February 7, 2025, at 3:55 PM, revealed that on February 4, 2025, the facility was contacted by the pharmacy regarding utilization of the Pyxis (automated medication dispensing system typically used in long-term care for when an ordered medication is not available from the pharmacy) for Resident 16's Tramadol 50mg. The pharmacist indicated that 30 tablets of Tramadol 50 mg had been delivered to the facility on [DATE], for Resident 16. Given that the medication had already been delivered, the use of Pyxis for dispensing this medication should not have been necessary.</p> <p>According to the investigation, Employee 8, a licensed practical nurse (LPN), received and signed for the pharmacy delivery of two cards of narcotic medications on January 27, 2025, at 6:23 PM. One of these medication cards contained Tramadol 50 mg, prescribed for Resident 16. After signing for the delivery, Employee 8 placed the medications in the medication room next to the gray pharmacy return bin and informed Employee 11, an agency LPN, of their location. The medications were left unattended in the medication room. When contacted by the Director of Nursing, Employee 11 stated she did not recall seeing or handling the Tramadol medication intended for Resident 16.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of the facility investigation indicated that upon review of video footage, Employee 11 was observed opening the narcotic drawer of her assigned medication cart and leaving it open while she stepped away to punch holes in a piece of paper. At this time, two cards of medication were visibly placed on top of the cart. Upon returning, Employee 11 placed one card of medication into the narcotic drawer but left the drawer open again as she stepped away a second time to punch holes in another piece of paper, leaving the second card of medication unsecured on the cart. After completing this task, Employee 11 placed the second card of medication into the narcotic drawer and then closed and locked the drawer. At approximately 7:22 PM, Employee 11 was seen removing a card of controlled medication from the narcotic drawer, placing it on top of the medication cart, and pushing the cart down the hallway, moving out of the camera's view.</p> <p>There was no evidence that the facility obtained written witness statements from Employee 8 or Employee 11 regarding the delivery or handling of the controlled substances.</p> <p>on January 27, 2025.</p> <p>A review of the controlled substance shift to shift count sheet revealed that on January 27, 2025, completed for the Mauve Hall, where Resident 16 resides, revealed that each on-coming, and off-going nurse confirmed that all controlled medications were accounted for. Despite controlled substance shift-to-shift count sheets confirming medications were accounted for on January 27, 2025, discrepancies were noted after the pharmacy alerted the facility of missing medications on February 4, 2025.</p> <p>There was no evidence of interviews or written statements from other nursing staff assigned to the Mauve Hall medication cart from January 27, 2025, to February 4, 2025.</p> <p>Although Resident 16 did not miss any doses due to an existing supply of Tramadol, the misappropriation of medication was confirmed. The investigation failed to identify the perpetrator responsible for the missing controlled substances. The facility failed to establish and implement effective procedures to prevent the misappropriation of resident property, specifically controlled medications.</p> <p>28 Pa. Code 201.29 (a)(c) Resident rights</p> <p>28 Pa. Code 201.18 (e)(1) Management</p> <p>28 Pa. Code 211.9 (a)(1)(b)(d)(k) Pharmacy services</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>39929</p> <p>Based on a review of the facility's abuse prohibition policy, employee personnel files and staff interviews, it was determined the facility failed to fully develop and implement its established abuse prohibition procedures by not adequately screening five of five employees for employment (Employee 5, 6, 7, 8 and 10).</p> <p>Findings include:</p> <p>According to regulatory requirements under SS483.12(a)(3) and 483.12(b)(1)] the facility must have written procedures for screening for prospective employees, to include reviewing:</p> <p>the employment history (e.g., dates of employment position or title), particularly where there is a pattern of inconsistency; information from former employers, whether favorable or unfavorable; and/or documentation of status and any disciplinary actions from licensing or registration boards and other registries.</p> <p>A review of the facility's Resident Abuse policy last reviewed by the facility December 2023, revealed the requirement for screening potential employees that including obtaining references from current or previous employers.</p> <p>Review of employee personnel files revealed the following:</p> <p>Employee 5 (Licensed Practical Nurse - LPN): Hired on January 13, 2025. The application listed previous employers, but there was no documentation showing the facility had contacted any former employers.</p> <p>Employee 6 (Nurse Aide): Hired on December 13, 2024. The application listed prior employers, yet no evidence was found to verify that the facility obtained references or employment information from previous employers.</p> <p>Employee 7 (Dietary Aide): Hired on November 18, 2024. The employee had indicated previous employment, but no verification of past employment was documented.</p> <p>Employee 8 (Licensed Practical Nurse - LPN): Hired on October 26, 2024. The application reflected prior employment, but there was no indication of efforts made to verify previous employment.</p> <p>Employee 10 (Director of Nursing - DON): Hired on September 26, 2024. Although the application listed previous employers, the facility did not document any contact with those employers for employment verification.</p> <p>Interview with the Administrator on February 13, at 12:15 p.m. the NHA verified that there was no evidence that previous employers were contacted for information regarding the employees past work history. The facility failed to follow its own abuse prohibition policy and by not verifying previous employment for five out of five new hires.</p> <p>(continued on next page)</p>		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 201.29 (a)(c) Resident Rights 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.19 (1) Personnel records

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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460</p> <p>Based on a review of clinical records and facility-initiated transfer notices and a staff interviews, it was determined the facility failed to provide written notice of facility-initiated hospital transfer to the resident and their representative for one resident out of the 18 residents sampled. (Resident 46).</p> <p>Findings include:</p> <p>A review of Resident 46's clinical record revealed the resident was initially admitted to the facility on [DATE], with diagnoses that included atrial fibrillation (irregular heartbeat), heart disease, and fracture of the left radius and left ulna styloid process (break of the two main bones in the forearm near the wrist).</p> <p>A review of the clinical record revealed that Resident 46 was transferred to the hospital on January 6, 2025, and was readmitted to the facility on [DATE].</p> <p>A review of the clinical record failed to reveal documented evidence the facility provided the resident and resident responsible party (RP) with a written notice of the facility-initiated transfer and reason for the transfer on January 6, 2025.</p> <p>An interview with the Administrator on February 13, 2025, at 9:40 a.m., confirmed the facility had no documented evidence indicating the resident's RP was informed of the transfer in writing.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460</p> <p>Based on a review of clinical records, facility documentation, staff interviews, and direct observation, it was determined the facility failed to provide necessary care and services to prevent urinary tract infections (UTIs) to the extent possible for one resident (Resident 65) with an indwelling urinary catheter out of 18 sampled residents.</p> <p>Findings included:</p> <p>Clinical record review revealed Resident 65 was admitted to the facility on [DATE], with diagnoses, which included urinary tract infection, benign prostatic hyperplasia (BPH an enlargement of the prostate gland common in older men and required the use of an indwelling catheter (rubber tubing inserted and retained in the bladder for continuous drainage of urine into a closed system) for urination.</p> <p>Review of a facility investigative report dated January 13, 2025, indicated that Resident 65 sustained a fall. According to the resident's statement, he just fell over the tubes, I'm fine.</p> <p>Further review of the facility investigative report revealed the resident's indwelling catheter drainage bag is changed to a leg bag during the daytime hours vs a larger drainage bag that hangs from the bed or a wheelchair.</p> <p>A review of the resident's care plan, last updated on February 12, 2025, did not identify or document the utilization of a leg bag for urinary drainage during daytime hours, despite this being part of the resident's routine care practices. This lack of documentation represents a failure to individualize care to address the specific needs of the resident.</p> <p>During observation on February 12, 2025, at approximately 11:30 AM, Resident 65's urinary drainage bag was noted to be inside a clear garbage bag, tied to the railing beside the toilet in the resident's bathroom. Notably, it was placed next to another resident's drainage bag, posing a risk for cross-contamination. The drainage bag contained approximately 200 mL of amber urine at the base, and additional urine was visible in the tubing. Improper storage and handling of urinary drainage systems increase the likelihood of bacterial contamination, thus violating infection prevention standards.</p> <p>During an interview with the Director of Nursing (DON) on February 12, 2025, at 12:00 PM, the DON confirmed the urinary drainage bags were not being cleaned or stored according to infection control guidelines. At the time of interview with the Director of Nursing, the facility could not provide evidence that the facility nursing staff were provided education related to the care and maintenance of urinary drainage systems. The DON was also unable to provide the surveyor with a facility policy or procedure outlining infection control practices specific to the care and maintenance of urinary catheters and drainage systems.</p> <p>Interview with the Director of Nursing confirmed the facility failed to provide appropriate care and services for a resident with an indwelling catheter and a history of urinary tract infections.</p> <p>(continued on next page)</p>		

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12 (d)(3)(5) Nursing services 28 Pa. Code 211.10 (a)(c)(d) Resident care policies

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944</p> <p>Based on clinical record and select facility policy review and staff interviews, it was determined the facility failed to provide effective pain management and administer pain medication as prescribed by the physician and failed to attempt non-pharmacological interventions to alleviate pain prior to the administration of a narcotic pain medication prescribed on an as needed basis for one resident out of six residents sampled for pain (Resident 5).</p> <p>Findings include:</p> <p>A review of the facility's policy entitled Pain Management with a policy review date of January 2025, indicated that strategies for pain management include to develop and implement both nonpharmacological and pharmacological interventions and approaches to pain management. The resident's plan of care must be individualized for nonpharmacological and pharmacological modalities and updated accordingly to changes and interventions and pain management.</p> <p>The facility utilizes the 0-10 Numerical Rating Scale (NRS a single-item question that asks the patient to rate his or her pain on a scale of 0 to 10, using the anchors of no pain and worse pain imaginable)) for pain assessment:</p> <p>1-3: Mild pain</p> <p>4-6: Moderate pain</p> <p>7-9: Severe pain</p> <p>10: Worst pain imaginable</p> <p>A review of Resident 5's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included cerebral palsy (CP refers to a group of neurological disorders that appear in infancy or early childhood and permanently affect body movement and muscle coordination and is caused by damage to or abnormalities inside the developing brain that disrupt the brain's ability to control movement and maintain posture and balance), dysphagia (difficulty swallowing), contractures (shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement) to the right elbow and right and left hand, and cerebral infarction (occurs when the blood supply to part of the brain is blocked or reduced and prevents brain tissue from getting oxygen and nutrients resulting in brain cells dying).</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 5's comprehensive person-centered plan of care initiated on June 26, 2020, indicated the resident had a potential for pain related to diagnoses such as cervicalgia (is pain felt in the neck and can be in the neck bones, ligaments or muscles), contractures left hip and knee and to the right elbow and wrist, and osteoarthritis right hip with a resident goal to have adequate relief of pain or ability to cope with incompletely relieved pain. Planned pain relieving interventions included to offer non-pharmacological interventions prior to medication administration, evaluate the effectiveness of pain interventions and review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition, and analgesic (also referred to as a pain reliever, or painkiller, is any member of the group of drugs used for pain management), medications per MD orders.</p> <p>A review of Resident 5's physician orders and Medication Administration Records (MAR - is used to document medications taken by each resident) revealed the following:</p> <p>Order dated June 12, 2023, at 2:15 PM, Tylenol Tablet 325 mg (Acetaminophen), give 2 tablets by mouth every 4 hours as needed for pain (PRN) - mild pain mild.</p> <p>A review the resident's MAR dated January 1, 2025, through survey ending February 14, 2025, revealed that Tylenol Tablet 325 mg was administered without documented attempts of nonpharmacological interventions and/or outside of the prescribed physician orders.</p> <p>January 5, 2025, at 12:06 PM, administered PRN pain medication for a reported pain level at 5 (moderate pain) and without attempted nonpharmacological interventions.</p> <p>January 7, 2025, at 11:34 PM, administered PRN without attempted nonpharmacological interventions.</p> <p>January 9, 2025, at 1:55 PM, administered PRN without attempted nonpharmacological interventions.</p> <p>January 15, 2025, at 1:55 PM, administered PRN without attempted nonpharmacological interventions.</p> <p>January 18, 2025, at 1:37 PM, administered PRN without attempted nonpharmacological interventions.</p> <p>January 19, 2025, at 1:19 AM, administered PRN pain medication for a reported pain level at 5 (moderate pain) and without attempted nonpharmacological interventions.</p> <p>January 19, 2025, at 1:09 PM, administered PRN pain medication without attempted nonpharmacological interventions.</p> <p>January 22, 2025, at 3:08 AM, administered PRN pain medication without attempted nonpharmacological interventions.</p> <p>January 23, 2025, at 5:16 AM, administered PRN pain medication without attempted nonpharmacological interventions.</p> <p>January 26, 2025, at 9:17 PM, administered PRN pain medication without attempted nonpharmacological interventions.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>January 27, 2025, at 4:30 AM, administered PRN pain medication without attempted nonpharmacological interventions.</p> <p>January 28, 2025, at 1:19 AM, administered PRN without attempted nonpharmacological interventions.</p> <p>January 28, 2025, at 8:37 PM, administered PRN pain medication for a reported pain level at 4 (moderate pain) and without attempted nonpharmacological interventions.</p> <p>January 29, 2025, at 8:11 AM, administered PRN without attempted nonpharmacological interventions.</p> <p>January 29, 2025, at 3:51 PM, administered PRN without attempted nonpharmacological interventions.</p> <p>January 30, 2025, at 11:16 AM, administered PRN without attempted nonpharmacological interventions.</p> <p>February 3, 2025, at 10:52 PM, administered PRN without attempted nonpharmacological interventions.</p> <p>February 8, 2025, at 6:07 AM, administered PRN pain medication for a reported pain level at 4 (moderate pain) and without attempted nonpharmacological interventions.</p> <p>February 9, 2025, at 5:54 PM, administered PRN without attempted nonpharmacological interventions.</p> <p>February 10, 2025, at 6:40 PM, administered PRN without attempted nonpharmacological interventions.</p> <p>February 11, 2025, at 5:21 AM, administered PRN without attempted nonpharmacological interventions.</p> <p>February 12, 2025, at 6:46 PM, administered PRN without attempted nonpharmacological interventions.</p> <p>A physician's order dated January 29, 2025, at 10:45 PM, Oxycodone HCl (an opioid pain medications) Oral Tablet 5 mg (Oxycodone HCl), give 1 tablet by mouth every 4 hours as needed for moderate pain for 14 Days and discontinued on February 4, 2025, at 2:52 PM.</p> <p>Additionally, a review the resident's MAR dated January 29, 2025, through February 4, 2025, revealed that Oxycodone HCl (an opioid pain medications) Oral Tablet 5 mg was administered without corresponding attempts at non-pharmacological interventions and, at times, outside of prescribed physician orders for pain level documentation.</p> <p>January 29, 2025, at 10:46 AM, administered PRN opioid without attempted nonpharmacological interventions.</p> <p>January 29, 2025, at 5:49 PM, administered PRN opioid without attempted nonpharmacological interventions.</p> <p>January 30, 2025, at 12:07 PM, administered PRN opioid without attempted nonpharmacological interventions.</p> <p>January 30, 2025, at 6:40 PM, administered PRN opioid without attempted nonpharmacological interventions.</p> <p>(continued on next page)</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>January 31, 2025, at 9:02 AM, administered PRN opioid without attempted nonpharmacological interventions.</p> <p>January 31, 2025, at 4:27 PM, administered a PRN opioid without attempted nonpharmacological interventions.</p> <p>February 1, 2025, at 5:37 AM, administered an opioid PRN pain medication for a reported pain level at 7 and without attempted nonpharmacological interventions.</p> <p>February 1, 2025, at 9:44 AM, administered an opioid PRN pain medication for a reported pain level at 7 and without attempted nonpharmacological interventions.</p> <p>February 1, 2025, at 2:50 PM, administered an opioid PRN without attempted nonpharmacological interventions.</p> <p>February 1, 2025, at 7:07 PM, administered an opioid PRN pain medication for a reported pain level at 7 (severe pain) and without attempted nonpharmacological interventions.</p> <p>February 2, 2025, at 7:08 AM, administered an opioid PRN pain medication for a reported pain level at 9 (severe pain) and without attempted nonpharmacological interventions.</p> <p>February 2, 2025, at 7:02 PM, administered an opioid PRN without attempted nonpharmacological interventions.</p> <p>February 3, 2025, at 7:43 AM, administered an opioid PRN without attempted nonpharmacological interventions.</p> <p>February 3, 2025, at 12:41 PM, administered an opioid PRN without attempted nonpharmacological interventions.</p> <p>February 3, 2025, at 8:00 PM, administered an opioid PRN without attempted nonpharmacological interventions.</p> <p>February 4, 2025, at 7:29 AM, administered an opioid PRN pain medication for a reported pain level at 7 (severe pain) and without attempted nonpharmacological interventions.</p> <p>A review of Resident 5's physician's orders revealed an order dated February 4, at 2:55 PM, revealed an order for Oxycodone-Acetaminophen Tablet 5- 325 mg, give 1 tablet by mouth every 6 hours as needed for pain (order did not specify pain intensity level to administer opioid medication).</p> <p>A review the resident's MAR dated February 4, 2025, through survey ending February 14, 2025, revealed that PRN Oxycodone-Acetaminophen Tablet 5- 325 mg was administered without documented attempts of nonpharmacological interventions and/or outside of the prescribed physician orders.</p> <p>February 5, 2025, at 7:39 AM, administered an opioid PRN pain medication for a reported pain level at 7 (severe pain) and without attempted nonpharmacological interventions.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>February 5, 2025, at 3:31 PM, administered an opioid PRN pain medication for a reported pain level at 7 (severe pain) and without attempted nonpharmacological interventions.</p> <p>February 5, 2025, at 10:40 PM, administered an opioid PRN pain medication for a reported pain level at 8 (severe pain) and without attempted nonpharmacological interventions.</p> <p>February 6, 2025, at 9:00 AM, administered an opioid PRN pain medication for a reported pain level at 7 (severe pain) and without attempted nonpharmacological interventions.</p> <p>February 6, 2025, at 4:50 PM, administered an opioid PRN pain medication for a reported pain level at 10 ([NAME] pain imaginable) and without attempted nonpharmacological interventions.</p> <p>February 7, 2025, at 8:21 AM, administered an opioid PRN pain medication for a reported pain level at 7 (severe pain) and without attempted nonpharmacological interventions.</p> <p>February 7, 2025, at 6:45 PM, administered an opioid PRN pain medication for a reported pain level at 6 (moderate pain) and without attempted nonpharmacological interventions.</p> <p>February 8, 2025, at 8:09 PM, administered an opioid PRN pain medication for a reported pain level at 7 (severe pain) and without attempted nonpharmacological interventions.</p> <p>February 9, 2025, at 9:11 AM, administered an opioid PRN pain medication for a reported pain level at 7 (severe pain) and without attempted nonpharmacological interventions.</p> <p>February 9, 2025, at 6:46 PM, administered an opioid PRN pain medication for a reported pain level at 7 (severe pain) and without attempted nonpharmacological interventions.</p> <p>February 10, 2025, at 8:57 AM, administered an opioid PRN pain medication for a reported pain level at 6 (moderate pain) and without attempted nonpharmacological interventions.</p> <p>February 10, 2025, at 4:24 PM, administered an opioid PRN pain medication for a reported pain level at 6 (moderate pain) and without attempted nonpharmacological interventions.</p> <p>February 11, 2025, at 9:27 AM, administered an opioid PRN pain medication for a reported pain level at 7 (severe pain) and without attempted nonpharmacological interventions.</p> <p>Further review of physician's orders dated February 11, 2025, at 12:00 PM, revealed an order for Oxycodone-Acetaminophen Tablet 5- 325 mg, give 1 tablet by mouth every 6 hours as needed for a reported pain level 7-10.</p> <p>A review the resident's MAR dated February 11, 2025, through survey ending February 14, 2025, revealed that PRN Oxycodone-Acetaminophen Tablet 5- 325 mg was administered without documented attempts of nonpharmacological interventions and/or outside of the prescribed physician orders.</p> <p>February 11, 2025, at 3:52 PM, administered an opioid PRN pain medication without attempted nonpharmacological interventions.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>February 11, 2025, at 10:31 PM, administered an opioid PRN pain medication without attempted nonpharmacological interventions.</p> <p>February 12, 2025, at 7:42 AM, administered an opioid PRN pain medication without attempted nonpharmacological interventions.</p> <p>February 12, 2025, at 3:32 PM, administered an opioid PRN pain medication without attempted nonpharmacological interventions.</p> <p>February 12, 2025, at 11:20 PM, administered an opioid PRN pain medication without attempted nonpharmacological interventions.</p> <p>February 13, 2025, at 2:35 PM, administered an opioid PRN pain medication without attempted nonpharmacological interventions.</p> <p>February 14, 2025, at 4:27 AM, administered an opioid PRN pain medication without attempted nonpharmacological interventions.</p> <p>During an interview with the Director of Nursing (DON) on February 14, 2025, at 11:35 AM, confirmed the facility failed to assure that physician's orders included a pain level that corresponded to the resident's reported pain scale for Resident 5. The DON confirmed there was no documented evidence of non-pharmacological interventions being attempted prior to the administration of PRN pain medications and licensed nursing staff failed to consistently follow physician's orders for the administration of pain medications.</p> <p>28 Pa. Code 211.5(f) Medical records</p> <p>28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929</p> <p>Based on clinical record review and staff interviews, it was determined the facility failed to ensure each resident received the necessary behavioral health care in a timely manner to attain or maintain the highest practicable mental and psychosocial well-being for two of 18 residents sampled (Residents 33 and 8).</p> <p>Findings include:</p> <p>A review of Resident 33's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including dementia (a group of symptoms that affects memory, thinking and interferes with daily life).</p> <p>Further review of Resident 33's clinical record revealed the resident exhibited behaviors, including yelling out, auditory and visual hallucinations. A review of nursing progress notes from January and February of 2025 revealed an increase in these behaviors, the resident was noted to be having near daily auditory and visual hallucinations which were difficult to redirect.</p> <p>Review of Resident 33's care plan revealed a focus area regarding behaviors, including auditory and visual hallucinations, initiated by the facility on April 8, 2024. The resident's care plan regarding these behaviors had not been revised since October 2024.</p> <p>Review of a psychological progress note dated January 24, 2025, documented the resident stated, I'm okay. However, no follow-up interventions were implemented despite clinical evidence from nursing notes indicating worsening behavioral symptoms.</p> <p>A review of Resident 8's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including dementia.</p> <p>Further review of Resident 8's clinical record revealed the resident exhibited behaviors, including yelling out, restlessness, anxiety, aggression, crying, striking out at staff. A review of nursing progress notes from January 2025 and February of 2025 revealed an increase in these behaviors. The resident was noted to be having near daily behaviors of yelling out, crying, aggression, and restlessness which were difficult to redirect.</p> <p>Review of Resident 8's care plan revealed a focus area regarding behaviors including anxiety and aggression initiated by the facility on February 23, 2024. The resident's care plan regarding behaviors had not been revised since September 2024.</p> <p>A review of a psychological evaluation dated January 24, 2025, similarly, indicated the resident stated, I'm okay. However, no additional psychological interventions or adjustments to treatment plans were documented, despite ongoing and escalating behavioral concerns.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility failed to update residents 33 and 8's s care plans to reflect changes in behavior, as required for providing individualized and responsive care and provide ongoing and necessary psychological services to address the residents' deteriorating behavioral health, as evidenced by the absence of follow-up interventions in response to worsening symptoms</p> <p>During an interview with the Nursing Home Administrator (NHA), on February 14, 2025, at approximately 10:00 a.m., the NHA was unable to provide evidence that either Resident 33 or Resident 8 received psychological services aimed at maintaining or improving their mental and psychosocial well-being.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>