| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 395936 | A. Building<br>B. Wing | 05/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Wayne Woodlands Manor | 37 Woodlands Drive<br>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) |
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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on select facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to consistently assess, monitor, and respond to significant weight changes to identify nutritional risks and implement timely nutritional interventions for three of twenty-four residents reviewed (Residents 1, 41, and 28).Findings include: A review of a policy entitled Weight Change Monitoring and Management Policy last reviewed January 1, 2026, indicated that a systematic process for identifying, assessing, and documenting, and addressing significant weight changes in residents to promote optional nutritional status, recent avoidable weight loss or gain, and ensure compliance with federal and state regulations. The facility shall monitor resident weights routinely and promptly investigate significant weight changes. Residents experiencing clinically significant weight loss or gain will receive interdisciplinary assessment and intervention. Significant weights changes are considered clinically significant based on a 5 percent change within thirty days, 7.5 percent change in ninety days, and 10 percent change in one-hundred and eighty days. A significant weight change triggers a verification of weight accuracy with a reweight obtained withing twenty-four to forty-eight hours, a review of intake records, edema assessment, medication review, physician notification, and/or interdisciplinary review. Assessment includes nutritional intake patterns, functional abilities, swallowing function, behavioral factors, psychosocial issues, medical diagnosis, medication effects, and hydration status. The nutrition interventions include dietary consultation, nutritional supplements, food preferences, adaptive equipment, speech evaluation, meal environment modification, medication adjustment, and/or physician evaluation. Care planning includes care plan and review and revision, resident and family involvement as appropriate, measurable interventions and goals, and on-going monitoring. A review of the facility policy entitled Weighing and Measuring a Resident, last reviewed by the facility on January 1, 2026, indicated that a reweight was to be obtained within twenty-four to forty-eight hours when a resident had a 5 percent weight change in one month, a 5 pound change from the previous weight, or a 3 pound weight loss when the resident weighed one hundred pounds or less. The policy indicated that resident weights were reviewed weekly by the Registered Dietitian, and significant weight losses or gains were reported during the weekly Risk Meeting. The policy indicated that the Registered Dietitian communicated the need for additional weights to nursing administration. The policy indicated that the physician and family were to be notified of significant weight loss or gain, refusal of meals, and failure of interventions. The policy defined unplanned and undesired weight loss as significant when a resident lost 5 percent of body weight in one month, 7.5 percent in three months, or 10 percent in six months. The policy defined weight loss as severe when the loss was greater than 5 percent in one month, greater than 7.5 percent in three months, or greater than 10 percent in six months. A clinical record review revealed Resident 1 was admitted to the facility on [DATE], with diagnoses that included dementia (a brain disorder that slowly destroys a person's memory and thinking skills and characterized by a loss of cognitive functioning such as thinking, remembering, and reasoning that interfere with a person's daily life and activities), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and feeding difficulties (problems that interfere with the ability to eat or drink safely<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | and effectively, often involving multiple stages of the feeding process such as choosing and getting food to the mouth, chewing, and swallowing). A review of Resident 1's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated January 21, 2026, revealed that Resident 1 had moderate cognitive impairment with a BIMS score of 12 (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 8-12 indicates moderate cognitive impairment) and able to eat independently after staff set-up. A plan of care review revealed a nutrition at risk care plan was initiated on June 19, 2023, identified that Resident 1 had nutritional problems or potential for nutritional problem related to a medical need for a therapeutic diet, feeding difficulties, poor vision and hearing deficits, and history of significant weight loss with goals to maintain adequate nutritional status as evidence by maintaining weight and no signs or symptoms of malnutrition. Planned interventions included to monitor weight and report changes to the physician and Registered Dietitian (RD), provide and serve diet and supplements as ordered, monitor and record meal intakes for each meal, quarterly and PRN (as needed) nutrition assessments, and RD to evaluate and make changes and recommendations PRN. A clinical record review revealed that the most recent comprehensive nutrition assessment for Resident 1 was last completed on October 25, 2024, and no comprehensive nutrition assessments completed by a RD during 2025. Resident 1's clinical record failed to reveal that a comprehensive nutritional assessment was completed annually as required. A clinical record review revealed a late-entry quarterly nutrition/dietary note completed by Employee 4, the facility's former Registered Dietitian (RD), with an effective date of January 21, 2026, at 9:47 AM, and a creation date of February 26, 2026, at 9:56 AM. The note documented that Resident 1 continued a no-added-salt diet (a diet that limits added salt by omitting table salt and salt packets), regular food texture, and thin liquids. The note further documented that the resident required varying levels of assistance with meals, primarily set-up assistance and assistance cutting food. According to the note, the resident had adequate fluid intake and consumed between fifty percent and one hundred percent of meals during the previous thirty days. The note further documented the resident utilized adaptive dining equipment, including a Kennedy cup (a spill-resistant drinking cup) and an inner-lip plate (a plate with a raised edge designed to assist with self-feeding). The documented weight history reflected a current body weight of 139.8 pounds on January 2, 2026, compared to 140.4 pounds on December 2, 2025, 134.3 pounds on October 2, 2025, and 134.9 pounds on July 5, 2025. Employee 4 documented that the resident had no significant weight changes and maintained a relatively stable weight over the previous six months. However, a review of Resident 1's weight record revealed the resident weighed 144.2 pounds on February 2, 2026, 144.7 pounds on March 3, 2026, and 134.5 pounds on April 8, 2026. The weight record review revealed that Resident 1 experienced a significant weight loss of 10.2 pounds, or seven percent, within thirty-six days from March 3, 2026, to April 8, 2026. The clinical record failed to reveal evidence that Employee 4, the facility's former Registered Dietitian (RD), timely assessed the significant weight loss when it occurred. A review of a nutrition/dietary note completed by Employee 4 on April 20, 2026, at 11:54 AM, twelve days after the significant weight loss was identified, documented that Resident 1 continued to have adequate oral and fluid intake, consuming between fifty percent and one hundred percent of meals, and continued to utilize adaptive feeding equipment. The note acknowledged the resident experienced a significant weight loss of 10.2 pounds, or seven percent, from March 3, 2026, to April 8, 2026, but further documented there were no significant weight changes and that the resident's weight remained relatively stable over the previous six months. Employee 4 documented the weight loss was undesirable but related to advanced age and indicated that the February and March weights were unusually high, contributing to the observed weight loss. The note further indicated there had been no significant changes in meal intake, that current weights were consistent with weights obtained three and six months earlier, and that weight fluctuations could occur due to diuretics (medications used to remove excess fluid from the body).<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Employee 4 documented that the physician and responsible party were notified, the care plan was reviewed and revised, and the resident would continue to be monitored. Continued review of Resident 1's weight records revealed the resident weighed 135.7 pounds on April 13, 2026, and 130.7 pounds on April 22, 2026. The resident lost an additional five pounds within nine days. The clinical record failed to reveal evidence that the continued weight loss was timely identified and assessed or that additional nutritional interventions were developed and implemented to address the ongoing decline. A clinical record review revealed that Employee 5, the facility's RD, completed a nutrition/dietary note on April 30, 2026, at 11:27 AM. The note documented a current weight of 130.7 pounds, a significant weight loss of 7.5 percent in ninety days, continued downward weight trends, and that the resident was at her lowest recorded weight. Although meal intake remained between fifty percent and one hundred percent, Employee 5 recommended initiation of a nutritional juice supplement twice daily to promote weight maintenance. However, Resident 1's clinical record failed to reveal physician notification or responsible party notification regarding the continued significant weight loss. The clinical record failed to reveal a physician's order for the nutritional juice supplement or evidence that the recommended intervention was implemented. The facility failed to ensure comprehensive nutrition assessments were completed by an RD to evaluate Resident 1's nutritional and hydration status and develop interventions to address nutritional decline. The facility failed to ensure Resident 1's significant weight losses were timely identified, assessed, and addressed through appropriate nutritional interventions. Additionally, the facility failed to implement the nutritional juice supplement recommended by the RD. A clinical record review revealed a late-entry dietary note completed on December 29, 2025, documenting that Resident 41 continued on a regular diet with pureed texture and thin liquids and was able to eat mostly independently after staff set-up assistance. The note documented adequate fluid intake and meal intake ranging from twenty-five percent to one hundred percent. The resident also received frozen nutritional supplements and nutritional shakes three times daily with good acceptance. At that time, the Registered Dietitian (RD) documented that the resident's weight had remained relatively stable during the previous six months. However, a review of the clinical record failed to reveal evidence that an annual comprehensive nutrition assessment had been completed by the RD. The record revealed the last comprehensive nutrition assessment was completed on February 3, 2025. A review of Resident 41's weight records revealed the following documented weights: 89.2 pounds on February 1, 2026; 80.9 pounds on March 1, 2026; 97.1 pounds on March 6, 2026; and 81.1 pounds on March 12, 2026. The clinical record failed to reveal that reweights were obtained in accordance with facility policy despite the significant fluctuation in recorded weights. Further review of the weight records revealed Resident 41 experienced a significant weight loss of 8.3 pounds, or 9.3 percent, from February 1, 2026, to March 1, 2026. The March 12, 2026, weight of 81.1 pounds confirmed the resident continued to demonstrate a significant weight loss of approximately nine percent within one month. A review of a nutrition/dietary progress note completed by Employee 4, the facility's former RD, on March 18, 2026, at 10:55 AM, eighteen days after the significant weight loss was identified, documented that Resident 41 weighed 81.1 pounds and had a Body Mass Index (BMI, a measurement that compares a person's weight to height and is commonly used to assess nutritional status) of 16.9, indicating the resident was underweight. The note further documented that the March 6, 2026, weight of 97.1 pounds was considered an outlier, meaning a value that differed substantially from surrounding weight measurements. Employee 4 documented that the resident experienced a significant weight loss of 9.3 percent in one month and a significant weight loss of 10.8 percent in six months. The note identified the weight loss as undesirable and recommended discontinuing small portions, providing regular portions to promote meal intake, and obtaining weekly weights for two weeks to monitor weight trends. The clinical record revealed that Employee 4, the facility's former RD, failed to timely assess Resident 41's significant weight loss of 9.3 percent that occurred between February 1, 2026, and March 1, 2026. Continued review of Resident 41's weight records revealed the resident weighed 81.8 pounds on April 7, 2026, 72.7 pounds on May<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1, 2026, 69.2 pounds on May 8, 2026, and 79.6 pounds on May 19, 2026. At the surveyor's request, an additional weight was obtained on May 22, 2026, which recorded the resident's weight as 70.6 pounds. The clinical record failed to reveal that reweights were obtained in accordance with facility policy to verify the accuracy of the substantial weight fluctuations. Further review revealed that a nutrition/dietary progress note was not completed until May 12, 2026, despite the resident experiencing an additional significant weight loss of 11.1 percent from April 7, 2026, to May 1, 2026, and 15 percent from April 7, 2026, to May 8, 2026. The facility failed to obtain reweights as required by facility policy to verify the consistency and accuracy of Resident 41's recorded weights. The facility further failed to ensure timely identification, assessment, and intervention for significant weight loss to develop and implement nutritional interventions to address the resident's continued and progressive weight decline. A review of Resident 28's care plan revealed a nutrition-at-risk care plan was initiated on August 19, 2025. The care plan identified actual or potential nutritional concerns related to osteoarthritis (a condition that causes joint pain and stiffness), generalized muscle weakness, the need for a mechanically altered diet (a diet modified in texture to improve safety with eating), variable meal intake, and a history of significant weight loss. The care plan established goals for the resident to maintain adequate nutritional status, maintain weight, and consume meals as tolerated. Planned interventions included monitoring weights and reporting changes to the physician and Registered Dietitian (RD), providing prescribed diets and nutritional supplements, monitoring and documenting meal intake, completing nutrition assessments quarterly and as needed, and having the RD evaluate the resident and make recommendations as appropriate. However, a review of the clinical record failed to reveal documented evidence that the facility's RD completed a comprehensive nutrition assessment to evaluate Resident 28's nutritional and hydration status and identify interventions to address nutritional decline. A review of Resident 28's weight records revealed the resident weighed 108.9 pounds on December 15, 2025, 111.2 pounds on December 19, 2025, 111 pounds on December 26, 2025, 108.8 pounds on January 3, 2026, 92.2 pounds on February 11, 2026, 92.5 pounds on February 13, 2026, and 93.4 pounds on February 18, 2026. Review of the weight records revealed Resident 28 experienced a significant weight loss of 16.6 pounds, or 15.3 percent, within approximately one month from January 3, 2026, to February 11, 2026. A clinical record review revealed Employee 4, the facility's former RD, completed a nutrition high-risk/significant weight loss note on February 23, 2026, thirteen days after the significant weight loss had been identified. The note documented that the resident remained on a regular diet with regular texture and thin liquids, had adequate fluid intake, and consumed approximately fifty percent to one hundred percent of meals during the previous thirty days. The note further documented that the resident received high-calorie, high-protein oral nutritional supplements twice daily with documented one hundred percent acceptance according to the Medication Administration Record (MAR), as well as frozen nutritional supplements twice daily with acceptance ranging from fifty percent to one hundred percent. These supplements provided an additional 1,020 calories and 40 grams of protein daily. Despite these nutritional interventions, Employee 4 documented that the resident's Body Mass Index (BMI, a measurement comparing a person's weight to height that is commonly used to assess nutritional status) was 17.1, indicating the resident was underweight. The note documented that the resident weighed 93.4 pounds on February 18, 2026, 92.5 pounds on February 13, 2026, and 92.2 pounds on February 11, 2026, compared to 108.8 pounds on January 3, 2026, reflecting an unplanned weight loss of 16.6 pounds, or 15.2 percent, within one month. Additional weight comparisons documented a 15.2-pound weight loss over three months from 107.4 pounds on November 4, 2025, and a 31.3-pound weight loss over six months from the admission weight of 123.5 pounds on August 19, 2025. The note further documented that a weight of 113.3 pounds obtained on November 3, 2025, was considered an outlier, meaning a measurement that differs substantially from surrounding data points. Employee 4 documented that the weight loss was considered questionable due to the resident's reported good meal intake and acceptance of nutritional supplements and initiated weekly weights to evaluate the<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | accuracy and validity of the recorded weights. Although the note documented physician and responsible party notification, the clinical record failed to reveal evidence that the significant weight loss was timely assessed and addressed when initially identified on February 11, 2026. The clinical record revealed that Employee 4, the facility's former RD, failed to timely assess Resident 28's significant weight loss of 15.3 percent that occurred between January 3, 2026, and February 11, 2026. The facility failed to ensure completion of a comprehensive nutrition assessment by an RD to evaluate Resident 28's nutritional and hydration needs and develop interventions to address nutritional decline. The facility failed to ensure Resident 28's significant weight loss was timely identified, assessed, and addressed through appropriate nutritional interventions to prevent continued weight loss. During an interview on May 21, 2026, at 2:25 PM, the Nursing Home Administrator stated that Employee 4 resigned from the facility on April 24, 2026, and that affiliated hospital dietitians were providing coverage for the position. When the above findings were reviewed during the interview, the Nursing Home Administrator confirmed that no additional documentation was available to demonstrate that Resident 28's significant weight loss had been thoroughly assessed by an RD or that interventions had been timely developed and implemented to prevent further weight loss. 28 Pa Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c) (d)(3)(5) Nursing services. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on select facility policy, clinical record review, and staff interview it was determined the facility failed to document the use of non-pharmacological interventions prior to the administration of a psychotropic medication for one of 24 residents reviewed (Resident 101).Findings include: Federal requirements for the use of psychotropic medications expect that psychotropic medications are used only when necessary to treat a specific, documented condition. Non-pharmacological interventions are approaches that do not involve medications, such as verbal reassurance, redirection, environmental adjustments, or comfort measures, and are expected to be attempted and documented when clinically appropriate prior to the use of a PRN psychotropic medication. A review of the facility's policy titled Psychotropic Medication Monitoring and Management, reviewed January 1, 2026, indicated the facility is committed to minimizing the use of chemical restraints and is also committed to employing non-pharmacological interventions as a first line of treatment to maintain each resident's highest practicable mental, physical, and psychosocial well-being. An review of clinical records revealed Resident 101 was admitted to the facility on [DATE], with a diagnosis of instability of internal right knee prosthesis (the right knee replacement doesn't feel solid or secure). A review of Resident 101's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 7, 2026, revealed that Resident 72 was moderately cognitively impaired with a BIMS score of 12 (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 12-15 indicates normal thinking and memory, reflecting little to no cognitive impairment). A review of the clinical record revealed a physician order dated May 7, 2026, for Alprazolam 1mg (milligram)(medication that provides fast-acting relief when someone feels overwhelmed by anxiety or panic) every six hours as needed for anxiety. A review of the resident's medication administration record revealed Alprazolam 1mg was administered on the following days and times: May 10, 2026 at 4:16 PMMay 12, 2026 at 4:20 PMMay 13, 2026 at 8:17 AMMay 13, 2026 at 9:27 PMMay 14, 2026 at 8:45 PMMay 15, 2026 at 12:48 PMMay 17, 2026 at 8:38 AMMay 18, 2026 at 8:12 PMMay 19, 2026 at 8:31 AMReview of the the resident's clinical record failed to identify evidence that non-pharmacological interventions were attempted prior to administration of the medication on the above dates. During an interview on May 21, 2026, at 11:48 AM, the Director of Nursing confirmed that the clinical record did not contain documentation of non-pharmacologic interventions prior to the administration of the psychotropic medication used to treat anxiety on nine occasions as required by federal requirements and facility policy. 28 Pa. Code 211.2(3) Medical director. 28 Pa. Code 211.5(ii)(xi) Clinical records. 28 Pa. Code 211.8(e) Use of restraints. 28 Pa. Code 211.9(1) Pharmacy services. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (d)(1)(2)(5) Nursing services. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Resident Assessment Instrument (RAI) Manual, Minimum Data Set (MDS) assessments, clinical record review, resident observation, and staff interviews, it was determined the facility failed to ensure the MDS assessments accurately reflected the residents' status for two of 24 residents reviewed (Resident 3 & Resident 26). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (October 2025), which provides instructions for completing the Minimum Data Set (MDS, a federally required standardized assessment used to evaluate resident status and develop care plans), indicates the assessment must accurately reflect the resident's functional status and be completed with participation from appropriate health professionals. Facilities are required to code the MDS according to the specific instructions outlined in the RAI Manual to ensure accuracy, consistency, and regulatory compliance. Resident 3 was admitted to the facility on [DATE], with a diagnosis of chronic obstructive pulmonary disease (longˆterm lung condition that makes it harder to breathe). A review of Resident 3's quarterly Minimum Data Set assessment dated [DATE], revealed Resident 3 was moderate cognitive impairment with a BIMS score of 8 (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 8-12 means noticeable difficulties in memory, orientation, or both). The quarterly MDS, dated [DATE], section P (section related to physical restraints, any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot easily remove which restricts freedom or normal access to the body) documented Resident 3 used a trunk restraint when out of bed. Observation of Resident 3 on May 19, 2026, at 12:30 PM in the dining room and again on May 20, 2026 at 10:01 in the activities room did not reveal the use of any device restricting access to one's body, specifically the trunk. Resident 26 was admitted to the facility on [DATE] with a diagnoses of metabolic encephalopathy (the brain isn't working properly due to a chemical imbalance in the body). A review of Resident 26's quarterly Minimum Data Set assessment dated [DATE], revealed that Resident 26 was cognitively impaired with a BIMS score of 3 (a score of 0-7 means severe cognitive decline indicating Resident 26 had significant challenges with memory, orientation, or both). The quarterly MDS, dated [DATE], section J (section addressing falls) documented Resident 26 did not experience any falls since the prior assessment. A clinical record review revealed Resident 26 experienced a fall on February 23, 2026. During an interview on May 20, 2026, at 2:30 PM the Nursing Home Administrator (NHA) and Director of Nursing (DON) reviewed the above information and confirmed the MDS assessment data was inaccurate. 28 Pa. Code 211.5(f)(iii) Medical records. 28 Pa. Code 211.12(d)(1)(5) Nursing services. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on select facility policy review, clinical record review, observation, and staff interview, it was determined that the facility failed to develop and maintain a comprehensive, person-centered care plan that accurately reflected a resident's pain management needs and interventions for one of 24 residents reviewed (Resident 3).Findings include: Review of the facility's Care Plan policy, last reviewed January 1, 2026, revealed that a comprehensive care plan should include measurable goals and services necessary to meet a resident's medical, nursing, mental, and psychosocial needs. The policy indicated that the comprehensive care plan is intended to reflect treatment goals, identify services necessary to meet resident needs, and assist in preventing or reducing decline in functional status. Clinical record review revealed that Resident 3 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD, a long-term lung disease that makes breathing difficult). A review of Resident 3's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 25, 2026, revealed that Resident 3 was moderate cognitive impairment with a BIMS score of 8 (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 8-12 means noticeable difficulties in memory, orientation, or both). Review of the resident's current comprehensive care plan, initially developed June 17, 2025, identified a care-planned problem related to pain associated with degenerative joint disease (arthritis that causes wear and tear of the joints affecting areas such as the neck, back, and spine). The care plan goal indicated the resident would experience effective pain relief. Review of a nursing progress note dated February 16, 2026, revealed the resident's family requested the remote control for the resident's spinal cord stimulator (an implanted device that delivers mild electrical impulses to interrupt pain signals before they reach the brain). The note documented that the remote was provided to the family; however, the family subsequently reported the remote would not power on and left the facility with the device. Review of a physician order dated April 21, 2026, revealed the resident was scheduled to attend an appointment on May 26, 2026, with a consulting physician for evaluation of the spinal cord stimulator. Review of the resident's comprehensive pain management care plan failed to identify the presence of the implanted spinal cord stimulator, the location of the device remote, or the need for the remote to accompany the resident to appointments related to management of the device. During an interview conducted on May 22, 2026, at 8:45 a.m., the Director of Nursing stated that Resident 3 had an implanted spinal cord stimulator used for pain management. The Director of Nursing stated that the remote control for the device was stored in the medication room and was required to accompany the resident to appointments involving evaluation or management of the implanted device. The Director of Nursing confirmed the resident's comprehensive, resident-centered care plan did not include the implanted spinal cord stimulator or related care-planning interventions. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services. 28 Pa. Code 211.10 (c)(d) Resident care policies. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395936 | A. Building<br>B. Wing | 05/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Wayne Woodlands Manor | 37 Woodlands Drive<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on select facility policy, clinical record review, and staff interviews it was determined the facility staff failed to follow physician orders when administering pain medication for one resident out of 24 reviewed (Resident 86).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 a facility policy last reviewed by the facility on January 1, 2026, revealed the facility staff will implement the medication regimen as ordered. The policy revealed it is the staff responsibility to administer the medication as ordered, monitor, and document the resident's response to the medication. A review of Resident 86's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including muscle weakness and low back pain. A review of Resident 86's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 22, 2026, revealed that Resident 86 was moderately cognitively impaired with a BIMS score of 12 (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 8 through 12 indicates moderate cognitive impairment). A review of physician orders revealed the following: An order dated April 20, 2026, for Oxycodone 5 milligrams (a prescription opioid pain medication used to treat moderate to severe pain), one capsule by mouth every six hours as needed for moderate pain, defined as a pain rating of 4 through 6 on a 0 to 10 pain scale (a self-reported rating tool in which 0 indicates no pain and 10 indicates the worst pain imaginable). An order dated April 22, 2026, for Oxycodone 10 milligrams, one capsule by mouth every six hours as needed for severe pain, defined as a pain rating of 7 through 10. An order initially dated April 20, 2026, indicating that if the resident requested pain medication with a lower pain scale than the resident's reported pain level, staff could administer the medication of the resident's choice. A review of the April and May 2026 MARs revealed staff administered Oxycodone 5 milligrams on 17 occasions. Four of the 17 doses were administered when the resident's documented pain rating exceeded the ordered pain range of 4 through 6:April 21, 2026, at 12:08 PM, administered for a pain rating of 7.April 25, 2026, at 8:52 PM, administered for a pain rating of 7.April 27, 2026, at 10:06 AM, administered for a pain rating of 7.May 9, 2026, at 7:27 PM, administered for a pain rating of 8. Further review of the April and May 2026 MARs revealed that staff administered Oxycodone 10 milligrams on 20 occasions. On May 17, 2026, at 2:06 PM, staff administered Oxycodone 10 milligrams for a documented pain rating of 3, which was below the ordered pain range of 7 through 10. The clinical record contained no documentation indicating the resident requested a different pain medication than the medication specified for the documented pain rating, as permitted by the physician's order. During an interview on May 22, 2026, at 11:00 AM, the Director of Nursing reviewed the above findings and acknowledged staff did not administer the medications according to the physician-ordered pain scale parameters and the clinical record contained no documentation<br>(continued on next page) |

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|---|---|---|---|
| | 395936 | A. Building<br>B. Wing | 05/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Wayne Woodlands Manor | 37 Woodlands Drive<br>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.

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | supporting resident requests for alternative pain medication. 28 Pa Code 211.10 (c) Resident care policies. 28 Pa. Code 211.5(f)(viii)(x) Medical records. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 395936 | A. Building<br>B. Wing | 05/22/2026 |

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| Wayne Woodlands Manor | 37 Woodlands Drive<br>Waymart, PA 18472 |

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|---|---|
| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and resident and staff interviews, it was determined the facility failed to ensure residents received necessary behavioral health care in a timely manner to attain or maintain the highest practicable mental and psychosocial well-being for one of 24 residents sampled (Resident 41). Findings include: A review of Resident 41's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including neurocognitive disorder with Lewy body dementia (a progressive brain disorder that affects memory, thinking, behavior, movement, and sleep, and may cause confusion, visual hallucinations, and symptoms similar to Parkinson's disease). A review of Resident 41's Quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated [DATE], revealed that Resident 41 was severely cognitively impaired with a BIMS score of 3 (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 0 through 7 indicates severe cognitive impairment). A review of Resident 14's clinical record revealed the resident was admitted on [DATE], with diagnoses which included hypertension (high blood pressure). A review of Resident 14's Quarterly Minimum Data Set assessment dated [DATE], revealed that Resident 14 was cognitively intact with a BIMS score of 15 (13-15 indicates cognition is intact). During an interview with Resident 14, on [DATE], at 10:30 AM, she stated that her roommate Resident 41, had been exhibiting new behaviors, acting out attempting to hit staff and yelling at staff due to Resident 41 finding out her sister had died. She stated that even though her roommate was confused she had experienced moments of clarity and told her that it was harder because Resident 41's sister was younger than her. Review of Resident 41's clinical record revealed the only documentation regarding the resident's loss was a nursing progress note dated [DATE], completed by the facility's Employee 5 (Registered Dietician) regarding the residents continued weight loss, indicating that Resident 41's recent poor intakes could potentially be related to grief. There was no documented evidence that behavioral health services were provided to help the resident with her grief over the loss of her sister and to meet the behavioral needs of a resident who although confused was displaying psychosocial symptoms of her grief. Review of the resident's clinical record showed no social service notes or psychological services notes regarding the loss of the resident's sister. Review of resident's care plan, initiated by the facility on [DATE], did not reveal a care plan for grief. The resident's care plan did not address the resident's specific mental health concern or expression of psychosocial symptoms. During an interview with the Nursing Home Administrator (NHA), on [DATE], at 10:00 AM the NHA was unable to provide evidence that Resident 41 was being provided psychological services to maintain the highest practicable level of mental and psychosocial wellbeing. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1)(5) Nursing services. |