STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396082	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Lane Post Acute LLC	1615 East Boot Road East Goshen West Chester, PA 19380

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 22502 Based on clinical record review and interview with staff, it was determined that the facility failed to notify the State Long-Term Care (LTC) Ombudsman's office of residents transferred or discharged for three of three residents reviewed (Residents 50, 64, and 76). Findings include: Review of Resident 50's clinical record revealed a nursing progress note dated December 15, 2023, revealed that the resident had a new order to be sent to the hospital to be evaluated due to bilateral lower extremity pain. Further review of Resident 50's clinical record failed to reveal documented evidence that the State Ombudsman's office was notified of Resident 50's transfers from the facility to the hospital. Review of Resident 64's nursing progress notes dated March 17, 2024, at 10:14 p.m., revealed resident was sent back to the hospital for further treatment (right knee infection). Review of Resident 64's clinical record failed to reveal the State Ombudsman's office was notified of Resident 64's transfers from the facility to the hospital. Review of Resident 76's clinical progress notes dated January 12, 2024 revealed Resident 76 was sent to the hospital and admitted as a result of a urinary tract infection. Further review of Resident 76's clinical record failed to reveal evidence that the State Ombudsman's office was notified of the transfer to the hospital. Interview with the Nursing Home Administrator on April 19, 2024, at 10:40 a.m. confirmed that the facility did not notify the State Ombudsman's office when residents were transferred or discharged . 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(a) Management 28 Pa. Code 201.18(b)(3) Management (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396082	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.29(a) Resident rights

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22502 Based on review of the Resident Assessment Instrument User's Manual, clinical record review and staff interview, it was determined that the facility failed to ensure that the comprehensive Minimum Data Set assessments were completed in the required time frame for five of 12 residents reviewed (Residents 27, 166, 212, 214, 262) Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2019, indicated that a comprehensive admission MDS assessment was to be completed no later than 14 days following admission and an annual assessment not less than once every 12 months. Review of Resident 27's clinical record revealed that an admission MDS assessment with an ARD (assessment reference date - last day of the assessment's look-back period) of April 17, 2023. The MDS is not completed and is listed as in progress. Review of Resident 166's clinical record revealed an admission MDS assessment dated [DATE], was not completed and was listed as in progress. Review of Resident 212's clinical record revealed an admission MDS assessment with an ARD of April 11, 2024 was not initiated or submitted. Review of Resident 214's clinical record revealed an admission MDS assessment with an ARD of April 16, 2024 was not completed and was listed as in progress. Review of Resident 262's clinical records revealed that an annual assessment with an ARD of November 3, 2023, was not completed and was listed as in progress. 28 Pa Code 201.18(b)(1) Management Previously cited 6/23/23 28 Pa. Code 211.5(f) Clinical records. Previously cited 6/23/23

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident’s assessment is updated at least once every 3 months. 22502 Based on review of the Resident Assessment Instrument User's Manual and clinical records, and staff interviews, it was determined that the facility failed to complete a quarterly Minimum Data Set assessments timely for four of 12 residents reviewed (Residentsv 5, 22, 50, and 211). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions for completing Minimum Data Set (MDS- assessments (mandated assessments of residents' abilities and care needs), dated October 2019, indicated that a quarterly assessment was to be completed within 92 days of the previous assessment's (any type) reference date. Review of Resident 5's clinical record revealed a quarterly assessment with an ARD (assessment reference date - last day of the assessment's look back period) of March 15, 2024. The assessment was not completed and is listed as in progress. Review of Resident 22's clinical record revealed a quarterly assessment with an ARD of March 6, 2024. The assessment was not completed. Review of Resident 50's clinical record revealed a quarterly assessment with an ARD of March 22, 2024. The assessment was not completed and is listed as in progress. Review of Resident 211's clinical record revealed a quarterly assessment with an ARD of November 14, 2023 was not completed and is listed as in progress. 28 Pa. Code: 211.12(d)(1)(5) Nursing services Previously cited 6/23/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22502 Based on clinical record review and staff interview, it was determined that the facility failed to ensure MDS assessments accurately reflected the resident's status for two of 12 residents reviewed (Residents 50 and 212). Findings include: Review of Resident 50's hospital readmission skin assessment dated [DATE], indicated resident had a left medial ankle venous stasis ulcer (slow healing sores on the legs caused by poor circulation). Review of the admission MDS assessment (Minimum Data Set - periodic assessment of resident needs) dated December 25, 2023, section M1030 Number of Venous and Arterial Ulcers indicated that Resident 50 did not have any venous or arterial ulcers. Interview with the Director of Nursing, on April 19, 2024, at 1:30 p.m. confirmed that Resident 50 was admitted with the venous ulcer and the the assessment did not accurately reflect the resident's status. Review of Resident 212's clinical progress note dated March 29, 2024 revealed Patient was admitted to Room [number] via stretcher accompanied by two attendees on March 29, 2024 at 1630 [4:30 p.m.] with DX [diagnosis] of left foot infection MRSA [methicillin resistant staph aureus]. Patient oriented to room medications discussed denies pain/discomfort at this time. VSS [vital signs stable] safety measures in place. Review of Resident 212's Admission/5 day MDS failed to reveal the diagnosis of MRSA to Resident 212's left foot. Interview with the Director of Nursing and Nursing Home Administrator on April 19, 2024 at 1:30 p.m. confirmed that Resident 212's admission MDS did not accurately reflect Resident 212's status. 483.20 Accuracy of Assessments Previously cited 6/23/23 28 Pa. Code 211.5(f) Clinical records Previously cited 6/23/23 28 Pa. Code: 211.12(d)(1)(5) Nursing services Previously cited 6/23/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure a qualified health professional conducts resident assessments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22502 Based on review of clinical records and Minimum Data Set (MDS-mandated assessments of a resident's abilities and care needs) assessments, and a staff interview, it was determined that the facility failed to timely certify the completion of the MDS assessments for nine of nine sampled residents (Residents 6, 40, 42, 50, 57, 65, 76, 77, and Resident 99). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required MDS assessments, dated [DATE], indicated that the MDS Completion Date must be no later than 14 days after the Assessment Reference Date. Review of Resident 6's progress note of [DATE], revealed that resident was discharged to home. Review of Resident 6's clinical record revealed that a discharge MDS assessment dated [DATE], was not completed and was listed as in progress. Review of progress note of [DATE], revealed that orders were received to discharge the resident home. Further review of the clinical record revealed that a discharge MDS assessment dated [DATE], was not completed and was listed as in progress. Review of Resident 40's progress note of [DATE], revealed that resident was discharged . Review of the clinical record revealed that a discharge MDS assessment dated [DATE], was not completed and was listed as in progress. Review of Resident 42's progress note of [DATE], revealed that the resident was discharged home. Review of the clinical record revealed that a discharge MDS assessment dated [DATE], was not completed and was listed as in progress. Review of Resident 50's progress note of [DATE], revealed that the resident was admitted to the hospital. Further review of the clinical record revealed that a discharge MDS assessment was not completed. Review of Resident 57's progress note of [DATE], revealed that resident was discharged home. Review of the clinical record revealed that a discharge MDS assessment dated [DATE], was not completed and was listed as in progress. Review of Resident 65's clinical record revealed Resident 65 was discharged to the community on February 1, 2024. Review of Resident 65's clinical record revealed Resident 65's discharge MDS was listed as in progress. Review of Resident 76's progress note of [DATE], revealed resident was admitted to the hospital. Further review of the clinical record failed to reveal evidence that a discharge MDS assessment was completed. (continued on next page)

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F 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident 77's progress note of [DATE], revealed that the resident was discharged home. Review of the clinical record revealed that a discharge MDS assessment dated [DATE], was not completed and was listed as in progress. Review of Resident 99's progress note dated February 14, 2024 revealed Resident 99 expired in the facility. Review of Resident 99's clinical record revealed Resident 99's Death in Facility MDS was listed as in progress. 28 Pa. Code: 211.12 (d)(1)(5) Nursing services. Previously cited [DATE]

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35913 Based upon review of clinical records, it was determined the facility failed to ensure baseline care plans were completed upon admission for three of 18 residents reviewed (Residents 93, 212 and 213). Findings include: Clinical records review revealed Resident 93 was admitted to the facility on [DATE], with a PICC (Peripherally Inserted Central Catheter) line to the right upper arm. Review of Resident 93's physician order dated April 12, 2024, revealed an order for Micafungin Sodium (Anti-fungal medication) Intravenous Solution 100mg one time a day for post abdominal surgery for ten days. Review of Resident 93's current care plan revealed that a care plan for the Resident's presence of PICC line and IV Anti-Fungal medication administration was not developed. Interview with the Director of Nursing on April 19, 2024, at 1:00 p.m., confirmed a baseline care plan for the presence of PICC line and IV anti-fungal medication was not developed for Resident 93. Review of Resident 212's clinical record revealed Resident 212 was admitted with a diagnosis of MRSA [methicillin resistant staph aureus - multi-drug resistant organism] of the left foot. Review of Resident 212's baseline care plan failed to reveal evidence that the MRSA of the left foot was included in the baseline care plan. Review of Resident 213's clinical record revealed Resident 213 was admitted to the facility on [DATE], with a colostomy. Review of Resident 213's baseline care plan failed to reveal evidence of the presence of a colostomy on admission. Interview with the Nursing Home Administrator and Director of Nursing on April 19, 2024, at 1:45 p.m. confirmed there was no baseline care plans initiated for Resident 212's MRSA and Resident 213's colostomy. 28 Pa. Code 211.5(f) Clinical records Previously cited 6/23/23 28 Pa. Code 211.11(a)(d) Resident care plans 28 Pa. Code: 211.12(d)(1)(5) Nursing services (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Previously cited 6/23/23

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22502 Based on review of clinical records and staff interview, it was determined that the facility failed to develop a comprehensive care plan for one of 12 residents reviewed (Resident 50). Findings include: Review of Resident 50's physician's orders included an order dated December 22, 2023, for Heparin Sodium (anticoagulant - blood thinner) Injection 5000 units subcutaneously (under the skin) every 12 hours. Review of Resident 50's current active care plan revealed no care plan or interventions for anticoagulant medication. Review of Resident 50's wound assessment dated [DATE], revealed resident had arterial wounds (wounds caused by poor circulation) of the right and left ankles, the left first MTP (metatarsophalangeal - joints connecting bones of the foot to the toes), right medial foot, right lateral ankle, and left and right heels. Resident 50 also had a venous ulcer (slow healing sore caused by weak blood circulation) of the left calf and pressure ulcers (areas of damaged skin and tissue caused by sustained pressure) to the right and left buttocks. Review of Resident 50's current active care plan revealed no care plan or interventions addressing the wounds. Interview with the Director of Nursing on April 19, 2024, at 1:30 confirmed that Resident 50 did not have a care plan to address the anticoagulant or wounds. 28 Pa. Code 211.5(f) Clinical records Previously cited 6/23/23 28 Pa. Code 211.12(d)(1)(5) Nursing services Previously cited 6/23/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765 Based on a review of the facility's policy, clinical records review, and staff interviews, it was determined that the facility failed to follow the physician's weight monitoring order for two of the 12 residents reviewed (Resident 64 and 263). Findings include: A review of the facility's policy titled Weights Policy, dated August 1, 2023, revealed residents will be weighed as directed by the physician, federal/state regulations, or standards of practice. Clinical records review revealed Resident 64 was readmitted to the facility on [DATE], with the following diagnoses: Lymphedema (A swelling that generally occurs in an arm or leg caused by lymphatic system blockage), and right knee infection. A review of Resident 64's physician's order sheet (POS) dated March 26, 2024, revealed an order for daily weights times three every day shift for monitoring for three days. Review of Resident 64's March 2024, Treatment Administration Record (TAR) revealed resident's weight was not done on March 27, and 28, 2024. Review of Resident 64's nursing progress notes dated March 27, 2024, revealed Hoyer lift was broken . Review of Resident 64's nursing progress notes dated March 28, 2024, revealed weight was unable to complete. Review of clinical record of Resident 263 revealed Residnets was admitted to the facility on [DATE], with a feeding tube (medical device used to provide nutrition to people who cannot obtain nutrition by mouth) due to a diagnosis of Cerebrovascular Accident (stroke). Review of Resident 263's physician order sheet dated April 8, 2024, revealed an order for daily weights times three every day shift for monitoring for three days. Review of Resident 263's April 2024, TAR, revealed a weight of 158 pounds (from the hospital) on April 9, 2024. No weight was taken on April 10, 2024. Interview with the dietitian, Employee E3 conducted on April 19, 2024, at 11:00 a.m., was conducted. Employee E3 reported that upon admission, the resident's weight should have been taken to get a baseline weight. Employee E3 confirmed that hospital weight should have not been used as a baseline weight when the resident was admitted to the facility. Employee E3 was unable to provide an answer as to why the physician's order regarding admission weight monitoring was not followed. The facility failed to ensure Resident 64 and 263's admission physician weight monitoring order was followed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396082	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.18(b)(1) Management Previously cited 6/23/23 28 Pa. Code 211.5(f) Clinical records Previously cited 6/23/23 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services Previously cited 6/23/23

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F 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

41765

Based on observations, clinical record reviews, as well as resident and staff interviews, it was determined that the facility failed to follow a physician's order and the wound specialist recommendation for one of four residents reviewed (Resident 262).

Findings include:

Review of Resident 262's clinical record revealed Resident 262 was admitted to the facility with a Stage 4 Pressure Ulcer (Full-thickness skin and tissue loss) to the sacrum.

Review of Resident 262's physician's order dated January 19, 2024, revealed a wound treatment to clean the sacral wound with an acetic wash, pat dry, and apply Medihoney (A dressing that aids and supports debridement and a moist wound healing environment in acute and chronic wounds and burns) with calcium alginate and cover with foam dressing.

Review of Resident 262's wound consult dated March 12, 2024, revealed improving the stage four wound to the sacrum, treatment recommendation was to cleanse the wound with saline solution (changed from Acetic wash), apply Medihoney with calcium alginate, and cover it with foam dressing.

Review of Resident 262's clinical record including, March 2024 and April 2024 Treatment Administration Record failed to reveal that the wound specialist recommendation made on March 12, 2024, to change acetic to normal saline was followed.

Observation of Resident 262's wound treatment with licensed nurse Employee E4 was conducted on April 19, 2024, at 11:00 a.m. During the wound observation, Employee E4 was observed cleaning the wound with an Acetic Solution.

Interview with the Director of Nursing conducted on April 19, 2024, revealed that any wound treatment recommendation from the wound specialist needed approval from the resident's primary physician.

Further review of Resident 262's clinical record failed to reveal that the primary physician was notified of the new wound treatment recommendation from the wound specialist on March 12, 2024.

The facility was unable to provide documentation and an answer as to why the recommendation from the wound specialist was not followed.

Review of the Resident 262's physician order dated August 30, 2023, revealed an order for the resident to be out of bed to a wheelchair for two hours in the room for lunch then put the resident back to bed after lunch (maximum of two hours out of bed) one time a day.

Observation conducted on April 17, 2024, at 1:00 p.m., revealed Resident 262 was in bed.

Observation conducted on April 18, 2024, at 1:38 p.m., revealed Resident 262 was in bed.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview was conducted with Resident 262 on April 18, 2024, at 1:40 p.m. The resident reported that no one had asked her/him to be out of bed. The resident reported that she/he was informed by the wound doctor that she/he needed to be out of bed for a few hours during lunch, but the staff would tell her/him that if she gets out of bed during lunch, that she/he might not get back to bed until after dinner. The resident verbalized wanting to be out of bed for a few hours, but this has not been happening for almost a month now. Interview was conducted with Nursing Assistant Employee E4 on April 18, 2024, at 2:00 p.m. Employee E4 reported that she/he was an agency staff. Employee E4 reported that Resident 262 was not offered to be out of bed because she/he was given a report that the resident does not get out of bed. The above information was conveyed to the Director of Nursing on April 19, 2024. The facility failed to ensure Resident 262's physician order and wound specialist wound treatment recommendations were followed. 28 Pa. Code 201.18(b)(1) Management Previously cited 6/23/23 28 Pa. Code 211.5(f) Clinical records Previously cited 6/23/23 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services Previously cited 6/23/23

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F 0690

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41765

Based on a review of the facility's policy, clinical records review, and staff interview, it was determined that the facility failed to provide treatment and services to maintain/restore bladder continence of one of the 12 residents reviewed (Resident 64).

Findings include:

Review of the facility's policy titled Bowel and Bladder - Continence, dated October 15, 2018, revealed that the facility has a standard in place for all residents related to bowel and bladder management and continence care. The procedure includes the following: Begin with a two-hour daytime voiding schedule; Approach the resident at the scheduled time; Wait five seconds to allow an opportunity to self-initiate toileting; Prompt the resident with verbal cueing if needed; Assist the resident with the toileting needs; Adjust the schedule up or down as needed, do not exceed four-hour intervals; and consult with therapy and nursing regarding changes/concerns.

Review of Resident 64's Admission Minimum Data Set (MDS- A standardized assessment tool that measures health status in long-term care residents) dated March 17, 2024, revealed resident was cognitively impaired and dependent on toileting. The same MDS revealed that Resident 64 bladder continence was always continent.

Review of Resident 64's clinical record revealed resident was hospitalized and was readmitted to the facility on [DATE].

Review of Resident 64's MDS dated [DATE], revealed resident was frequently incontinent with urine, which was a change from the March 17, 2024, MDS assessment.

Review of Resident 64's clinical record failed to reveal a comprehensive bladder continence assessment was completed after identifying a change in the resident's urinary continence.

The facility was unable to provide documentation of a treatment or services provided to monitor, restore/maintain Resident 64's urinary status.

Interview conducted with the Director of Nursing on April 19, 2024, at 12:30 p.m., confirmed that the facility failed to comprehensively assess Resident 64's urinary continence upon identifying a change and failed to implement treatment/services to restore and or maintain the resident's urinary status.

28 Pa. Code 201.18(b)(1) Management

Previously cited 6/23/23

28 Pa. Code 211.5(f) Clinical records

Previously cited 6/23/23

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396082	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Lane Post Acute LLC	1615 East Boot Road East Goshen West Chester, PA 19380

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1)(3)(5) Nursing services Previously cited 6/23/23 28 Pa. Code 211.10 (a)(d) Resident care policies

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396082	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024
NAME OF PROVIDER OR SUPPLIER Park Lane Post Acute LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 East Boot Road East Goshen West Chester, PA 19380	

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 41765 Based on clinical record reviews and staff interview, it was determined that the facility failed to ensure medications were made available for one of the 12 residents reviewed (Resident 93). Findings include: Review of Resident 93's diagnosis list includes hypertension (Elevated blood pressure), and Atherosclerotic Heart Disease (ASHD-heart condition in which an accumulation of fatty substances results in the narrowing of arteries and causing restriction in the flowing of blood). Review of Resident 93's physician order dated April 12, 2024, revealed an order for Verapamil HCL ER 240 mg(miligram) given one tablet daily by mouth at bedtime for hypertension. Review of Resident 93's April 2024, Medication Administration Record revealed Verapamil medication was not administered to the resident until April 16, 2024, four days after it was ordered. Review of Resident 93's nursing progress notes dated April 12, 2024, at 9:46 p.m., revealed medication on route from the pharmacy. Review of Resident 93's nursing progress notes dated April 14, 2024, at 8:07 p.m., revealed waiting for pharmacy to drop off (medication). Review of Resident 93's nursing progress notes dated April 15, 2024, at 10:58 p.m., revealed: called the pharmacy and is coming tonight. Review of Resident 93's pharmacy records revealed that Verapamil medication was not delivered from the pharmacy until April 15, 2024, at 11:12 p.m. Review of the facility's emergency medication available list does not include the medication Verapamil. The above information was discussed with the Director of Nursing on April 19, 2024, at 11:30 a.m. The facility failed to ensure Verapamil medication was available for Resident 93. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services Previously cited 6/23/23 28 Pa. Code: 211.9 (a)(1) Pharmacy services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396082	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Lane Post Acute LLC	1615 East Boot Road East Goshen West Chester, PA 19380

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 22502 Based upon review of facility policy and procedure, observation, and clinical record review, it was determined the facility failed to ensure enhanced barrier precautions were in place for residents requiring enhanced barrier precautions for three of three reviewed (Residents 50, 212, and 213). Findings include: Review of facility policy and procedure titled Enhanced Barrier Precautions, revised March 26, 2024, revealed Enhanced Barrier Precautions (EBP) expands the use of PPE beyond situations in which exposure to blood and body fluids is anticipated, refers to the use of gown and gloves during high contact resident care activities that provide opportunities for transfer of multidrug resistant organism (MDROs) to staff hands and clothing. Further review of facility policy and procedure revealed EBP are indicated for residents with any of the following and should be used: infection or colonization with a CDC-targeted MDRO when Contact Precautions do otherwise apply; or wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO; wounds in this policy refer generally to chronic wounds, not shorter lasting wounds such as skin breaks or tears covered with adhesive bandage or similar dressing. Examples of chronic wounds include but are not limited to pressure injuries, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers; indwelling medical device examples include central lines, urinary catheters, feeding tubes and tracheotomies. A peripheral intravenous line (not a peripherally inserted central catheter/PICC) is not considered an indwelling medical device for this policy. Further review of this policy revealed Examples of high contact resident care activities requiring gown and gloves for Enhanced Barrier Precautions include dressing, bathing/showering, transferring, providing hygiene, changing liens, changing briefs or assisting with toileting, device care or use, wound care - any skin opening requiring a dressing, contact during therapy in gyms, and transfers in shower rooms/bathing areas. Further review of this policy revealed Post EBP signage to communicate with associates the need for gown and gloves as applicable. Review of Resident 50's admission MDS (Minimum Data Set - periodic assessment of resident needs) dated December 25, 2023, revealed that the resident had an in-dwelling catheter (a flexible tube inserted into the bladder for removing fluid). Observations of Resident 50's room on the first three days of the survey failed to reveal evidence of EBP signage or PPE. Review of Resident 212's admission diagnosis list revealed a diagnosis of osteomyelitis of the left foot with MRSA (an MDRO). Observation of Resident 212's room on the first three days of the survey failed to reveal evidence of EBP signage or PPE. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident 213's admission diagnosis list indicated Resident 213 had a colostomy. Observation of Resident 213's room on the first three days of the survey failed to reveal evidence of EBP signage and failed to reveal evidence of PPE. Observation of the First-Floor nursing unit on the first three day of the survey failed to reveal evidence of any EBP signage on any resident room that required same. No PPE was present in resident rooms or hallways. Multiple observations of staff entering and exiting rooms requiring EBP failed to reveal evidence of any PPE in use. 28 Pa. Code 211.5(f) Clinical records Previously cited 6/23/23 28 Pa. Code: 211.12(d)(1)(5) Nursing services Previously cited 6/23/23