

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Exton Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 501 Thomas Jones Way Exton, PA 19341	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 41765 Based on review of facility's policy, clinical records and hospital record review, and interview with resident and staff, it was determined the facility failed to report a fall to the state agency for one of 19 residents reviewed (Resident 20). Findings include: Review of facility's policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised in September 2022, revealed that if resident abuse, neglect, exploitation, or theft/misappropriation is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator or the individual making the allegation immediately reports his or her suspicion to the following person or agencies: The state licensing /certification agency responsible for surveying /licensing the facility; the local state ombudsman; the resident's representative; Adult protective services; Law enforcement officials; The resident's attending physician and facility director. Immediately is defined within two hours of an allegation involving abuse or result in serious bodily injury; or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Review of Resident 20's Admission Minimum Data Set (MDS-a standardized assessment tool that measures health status in long-term care residents) dated October 21, 2024, revealed that the resident was cognitively intact. The same MDS revealed that the resident required partial/moderate assistance with toilet transfers. A review of Resident 20's nursing progress notes dated October 21, 2024, at 5:23 p.m., revealed that the Resident was sent to the hospital post-fall. The same note revealed Resident 20 was being transferred to the toilet with assistance from the NA (nurse assistant) when Resident 20 fell and hit their right leg causing the surgical incision to reopen. A review of Resident 20's physician's progress notes dated October 21, 2024, revealed resident was seen for an acute visit regarding a witnessed fall reported with a NA. The same note revealed that Resident 20 stated that they were still having a hard time coping with the new right BKA and did attempt to use the right leg with the transfer, causing Resident 20 to land right into their BKA incision. The right BKA incision split open with profuse bright red blood present and actively bleeding. Pressure dressing was applied immediately and they advised nursing to send the resident to the emergency room for evaluation and repair of the open incision. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 396144	Facility ID: 396144 If continuation sheet Page 1 of 20

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hospital record review dated October 29, 2024, revealed resident was admitted to the hospital on October 21, 2024, with diagnosis of right BKA wound dehiscence (a surgical complication in which a wound ruptures along a surgical incision) with bleeding secondary to mechanical trauma. An interview with Resident 20 conducted on January 13, 2025, at 10:30 a.m., revealed that a few days after they were admitted to the facility, a male staff assisted them from the wheelchair to the toilet commode. Resident 20 reported that it was always two people assisting with transfers but at that moment it was only one. The resident stated He/she taught he/she could handle me by him/herself The resident further reported that he lost balance during the transfer and fell hitting the right knee. A review of Resident 20's care plan developed on October 18, 2024, revealed an ADL (activities of daily living) care plan for the resident requiring assistance/dependent for ADL care with bathing, grooming, dressing, bed mobility, transfer, and toileting. An intervention initiated on October 18, 2024, revealed: Provide two persons assist with toilet transfer and toileting hygiene. An interview with the DON on January 16, 2025, at 10:00 a.m., confirmed that the incident was not reported to the state agency until January 14, 2025, after surveyor requested for the investigation of the incident. The facility failed to ensure Resident 20's fall due to failure to provide adequate assistance and supervision which led to hospitalization was reported to the state agency. 28 Pa. Code 211.10(d) Resident Care Policies Previously cited 8/22/24, 3/15/24, 5/18/23 28 Pa. Code 201.14(a) Responsibility of licensee Previously cited 8/22/24, 4/25/24, 3/15/24, 12/19/23, 5/18/23 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management Previously cited 8/22/24, 4/25/24, 3/15/24, 1/27/24, 12/19/23, 11/1/23, 5/18/23 28 Pa. Code 211.5(f) Clinical records Previously cited 8/22/24, 6/10/24, 4/25/24, 3/15/24, 1/27/24, 5/18/23 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing service Previously cited 8/22/24, 6/10/24, 4/25/24, 3/15/24, 1/27/24, 12/19/23, 11/1/23, 5/18/23		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765 Based on review of facility policy, clinical record review, hospital record review, and interviews with resident and staff, it was determined the facility failed to investigate a fall for one of 19 residents reviewed (Resident 20). Findings include: A review of facility's policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised in September 2022, revealed that all reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies and thoroughly investigated. The administrator initiates investigations. Upon conclusion of the investigation, the investigator records the findings of the investigation on approved documentation form. A review of Resident 20's clinical record revealed the resident was admitted to the facility on [DATE], with a diagnosis of post-right below knee amputation, Osteomyelitis (bone infection), and left trans metatarsal (foot bone)amputation. A review of Resident 20's Admission Minimum Data Set (MDS-a standardized assessment tool that measures health status in long-term care residents) dated October 21, 2024, revealed that the resident was cognitively intact. The same MDS revealed that the resident required partial/moderate assistance with toilet transfers. An interview with Resident 20 conducted on January 13, 2025, at 10:30 a.m., revealed that a few days after Resident 20 was admitted to the facility, a male staff assisted them from the wheelchair to the toilet commode. Resident 20 reported that it was always two people assisting with transfers but at that moment it was only one. The resident stated He/she taught he/she could handle me by him/herself. Resident 20 further reported that he lost balance during the transfer and fell hitting the right knee. Resident 20 reported that their surgical incision opened after the fall and was sent to the hospital. A review of Resident 20's care plan developed on October 18, 2024, revealed an ADL (activities of daily living) care plan for the resident requiring assistance/dependent for ADL care with bathing, grooming, dressing, bed mobility, transfer, and toileting. An intervention initiated on October 18, 2024, revealed: Provide two persons assist with toilet transfer and toileting hygiene. A review of the nursing progress notes dated October 21, 2024, at 5:23 p.m., revealed that the Resident was sent to the hospital post-fall. The same note revealed Resident was being transferred to the toilet by the NA (nurse assistant) when Resident 20 fell and hit their right leg causing the surgical incision to open. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the physician's progress notes dated October 21, 2024, revealed Resident 20 was seen for an acute visit regarding a witnessed fall reported with an NA (Nursing Assistant). The same note revealed that Resident 20 stated that they were still having a hard time coping with the new right BKA (Below Knee Amputation) and did attempt to use the right leg with the transfer, causing Resident 20 to land right into their BKA incision. The right BKA incision split open with profuse bright red blood present and actively bleeding. Pressure dressing was applied immediately and then advised nursing to send the resident to the emergency room for evaluation and repair of the open incision. Review of hospital records dated October 29, 2024, revealed Resident 20 was admitted to the hospital on October 21, 2024, with diagnosis of right BKA wound dehiscence (a surgical complication in which a wound ruptures along a surgical incision) with bleeding secondary to mechanical trauma. A review of the facility's documentation revealed an incident report of Resident 20's fall that occurred on October 21, 2024, at 5:00 p.m., completed by the Director of Nursing (DON). No further investigation documents were provided to the surveyor. An interview with the DON on January 16, 2025, at 10:00 a.m., confirmed that the incident report of Resident 20's fall that occurred on October 21, 2024, was just completed on January 14, 2025, after the surveyor asked for it. The DON confirmed that the incident was not investigated, and that the perpetrator was not identified. The facility failed to ensure Resident 20's fall due to failure to provide adequate assistance and supervision which led to hospitalization was investigated. 28 Pa. Code 211.10(d) Resident Care Policies Previously cited 8/22/24, 3/15/24, 5/18/23 28 Pa. Code 201.14(a) Responsibility of licensee Previously cited 8/22/24, 4/25/24, 3/15/24, 12/19/23, 5/18/23 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management Previously cited 8/22/24, 4/25/24, 3/15/24, 1/27/24, 12/19/23, 11/1/23, 5/18/23 28 Pa. Code 211.5(f) Clinical records Previously cited 8/22/24, 6/10/24, 4/25/24, 3/15/24, 1/27/24, 5/18/23 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing service Previously cited 8/22/24, 6/10/24, 4/25/24, 3/15/24, 1/27/24, 12/19/23, 11/1/23, 5/18/23		

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F 0684 Level of Harm - 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 clinical record review and staff interview, it was determined the facility failed to assist one of one (Resident 43) residents in making transportation arrangements to and from multiple orthopedic surgery appointments resulting in actual harm by causing a deterioration of the wound and being admitted to a hospital for wound washing, and failure to follow a medication order from the physician for one out 19 residents reviewed (Resident 30). Findings include: Review of Resident 43's admission Minimum Data Set (MDS) assessment (mandated assessment of a resident's abilities and care needs), dated November 29, 2024, revealed the resident was admitted on [DATE], was understood, could understand others, was cognitively intact, dependent on staff for care needs, and had a fracture of lower end of right femur (thigh bone), fracture of T9-T10 vertebra (spinal cord), fracture of ribs, fracture of lower end of left radius (forearm), displaced [NAME] fracture of left tibia (lower leg), other fracture of upper and lower end of left fibula (calf bone), displaced bicondylar fracture with nonunion (knee joint), and displaced bicondylar fracture of right tibia. Review of Resident 43's physician follow-up note dated January 10, 2025, at 2:33 p.m. revealed Resident 43 was evaluated due to nursing concerns over worsening right lower extremity (RLE) wound. Further review of the follow-up note revealed Resident 43 was not able to attend (his/her) orthopedic surgery appointment on January 6, 2025, due to not being able to cover the out-of-pocket expense. Review of wound care progress note dated January 10, 2024, revealed Patient has follow-up appointment with surgeon on January 13 regarding worsening right leg surgical repair, Transportation scheduled, and payment has been confirmed by husband. Nurse Practitioner (NP) aware of same. Review of Resident 43's physician follow-up note dated January 13, 2024, revealed Resident 43 was seen for a worsening right lower extremity (RLE) wound and concern for missed orthopedic surgery appointments and an order for Bactrim [double strength] tablet 800-160 milligrams, give 1 tablet by mouth every 12 hours for bacterial infection/worsening leg wound for 7 days and oxycodone [hydrochloride] oral tablet 5 milligrams, give one tablet by mouth every 4 hours as needed for moderate to severe pain. Further review revealed [Resident 43] wished the facility worked with a different service and was also upset that (he/she) was having to do follow ups and schedule them (him/herself). Interview conducted with Resident 43 on January 13, 2024, at 10:02 a.m. reported that (he/she) has missed multiple orthopedic surgery appointments (January 13, 2025, and January 6, 2025) due to not being able to cover the out-of-pocket expense to use [medical transportation services]. Resident 43 reported [medical transportation service] is the only transportation service the facility uses. Resident 43 reported each use of [medical transportation service] cost's a minimum of \$1,300. Subsequent interview with Resident 43 revealed resident is worried that (he/she) will miss additional orthopedic surgery appointments due to not being able to cover the cost. Resident 43 also reported the pain from her right lower extremity wound is intensifying, requiring staff to administer her oxycodone pain medication. (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 43's clinical record revealed a progress note dated January 15, 2025, at 5:30 p.m. indicating Per NP, patient's surgeon requesting patient be sent to [Hospital] for washout of RLE surgical wound. [Medical transportation company] transport arranged and patient left facility via ambulance. Husband and daughter updated. Interview with the Social Worker, Employee E13 on January 16, 2025, at 11:55 a.m. revealed, (he/she) was aware Resident 43 had missed multiple appointments due to the inability to cover the out-of-pocket expenses. Social Worker, Employee E13 acknowledged, (he/she) had not attempted to arrange alternative transportation options or provided Resident 43 with resources to secure (his/her) own transportation. Interview with the Director of Nursing (DON) on January 16, 2025, at 1:15 p.m. revealed the facility did not follow up with [medical transport company] to determine why Resident 43 was not transported to her orthopedic surgery appointment on January 13, 2025. A follow-up interview with the Director of Nursing (DON) on January 16, 2025, at 1:59 p.m. revealed she had contacted [medical transport company] to inquire why Resident 43 was not transported to medical appointment. The DON reported the [medical transport company] did not provide transportation due to Resident 43 inability to cover the out-of-pocket expense. She further stated that she was unaware Resident 43 could not cover this expense and that the facility will attempt to schedule virtual appointments with the resident's orthopedic surgeon in the future. The Director of Nursing (DON) confirmed the previous statements and acknowledged the facility should have assisted Resident 43 in arranging alternative transportation to resident's orthopedic surgeon appointments. The DON reported Resident 43 was admitted to the Hospital for wound treatment and did not know when Resident 43 would be returning to the facility and did not have access to Resident 43's hospital records. The facility failed to ensure Resident 43 attended the orthopedic surgical follow-up appointments by not providing alternative modes of transportation or scheduling virtual appointments causing actual harm to Resident 43 when the surgical wound deteriorated and Resident 43 needed to be hospitalized for care to the worsening wound. Review of Resident 30's diagnosis list includes Acute Respiratory Failure (life-threatening condition where the lungs cannot adequately exchange oxygen and carbon dioxide, leading to low blood oxygen levels) and a history of Pulmonary Embolism (blood clot that blocks and stops blood flow to an artery in the lung). Review of Resident 30's physician order dated December 17, 2024, revealed an order for Enoxaparin Sodium Injection 80 mg/0.8 ml. Inject 0.8 ml (milliliter) subcutaneously (shot given into the fatty layer of tissue beneath the skin) every 12 hours for DVT (Deep Vein Thrombosis- clot in the deep vein). The medication was ordered to be administered at 9:00 a.m., and 9:00 p.m. Review of Resident 30's January 2025, Medication Administration Record revealed from January 7, 2025, until January 15, 2025, Resident 30 was not administered the medication on the following dates and times: January 7, 2025, at 9:00 a.m., January 8, 2025, at 9:00 p.m., January 9, 2025, at 9:00 a.m., and 9:00 p.m. (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the nursing progress notes dated January 7, 2025, at 12:36 a.m., revealed medication on order, NP aware. Review of Resident 30's nursing progress notes dated January 8, 2025, at 8:29 p.m., and January 9, 2025, at 8:20 p.m., each note revealed medication was on order with the pharmacy. Review of Resident 30's clinical records failed to reveal the physician was notified of the missed medications on the evening of January 8, 2025, and the morning and evening dose on January 9, 2025. Review of the pharmacy documentation revealed Enoxaparin medication was available in the facility for emergency use. An interview with the Director of Nursing conducted on January 16, 2024, at 10:00 a.m., failed to provide an explanation why the medication was not administered to the resident despite being available in the facility. The facility failed to ensure Resident 30's physician's medication order was followed. 28 Pa. Code 201.14(a) Responsibility of licensee Previously cited 8/22/24, 4/25/24, 3/15/24, 12/19/23, 5/18/23 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management Previously cited 8/22/24, 4/25/24, 3/15/24, 1/27/24, 12/19/23, 11/1/23, 5/18/23 28 Pa. Code 211.5(f) Clinical records Previously cited 8/22/24, 6/10/24, 4/25/24, 3/15/24, 1/27/24, 5/18/23 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing service Previously cited 8/22/24, 6/10/24, 4/25/24, 3/15/24, 1/27/24, 12/19/23, 11/1/23, 5/18/23		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765 Based on clinical records review and staff interviews, it was determined that the facility failed to follow the wound treatment recommended by the wound specialist in a timely manner for one of the 11 residents reviewed (Resident 28). Findings include: Clinical record review revealed Resident 28 was admitted to the facility on [DATE], with a Stage 3 Pressure Ulcer (full thickness skin loss) to the midback. The physician's order dated December 9, 2024, revealed an order to cleanse the wound with normal saline solution, apply Hydrogel (a wound dressing that keeps the wound moist and closed), and cover with Optifoam dressing every morning shift every other day. A review of the wound physician consult dated December 11, 2024, revealed that the midback remained a stage three wound measuring 0.9 x 0.9 x 0.1 cm. An order to cleanse the wound with normal saline solution, apply Hydrogel, and cover with a bordered dressing daily was made. A review of the December 2024, Treatment Administration Record (TAR) revealed that the new order was not followed until December 18, 2024. Resident 28's midback wound was treated every other day instead of the ordered daily treatment from December 11, 2024, until December 18, 2024, missing four days of wound treatment. An interview was conducted with the wound nurse, Employee E6 on January 15, 2025, at 1:00 p.m. Employee E6 reported that the conduct wound rounds with the wound physician weekly. Employee E6 reported that the primary physician automatically approves the wound physician's recommendations. Employee E6 reported that they were responsible for placing the order into the system. When asked for the reason why the order was not changed until December 18, 2024, seven days after it was ordered, Employee E6 responded that it was missed. Clinical record review failed to reveal that the physician was notified of the missed wound treatments. A review of the wound physician consult dated January 1, 2025, revealed an Unstageable Pressure Ulcer (Obscured full-thickness skin and tissue loss) to midback with measurements of 1.7 x 1.0 x 0.1 cm., with 60% slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy, and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed). Wound physician ordered to cleanse the wound with normal saline and apply Santyl (A topical medication used for removing damaged or burned skin to allow for wound healing and growth of healthy skin) to calcium alginate (used to ensure a wound remains moist), place to the wound bed, cover with bordered dressing daily. A review of December 2024, TAR revealed Santyl wound treatment ordered on January 1, 2024, was not implemented until January 10, 2025, ten days after the order was made. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Employee E6 on January 15, 2025, at 1:00 p.m., was conducted. Employee E6 failed to explain as to why Santyl's order was not implemented timely. The above was conveyed to the Director of Nursing on January 16, 2025, at 10:00 a.m. The facility failed to ensure Resident 28's wound treatment order was implemented timely. 28 Pa. Code 211.5(f) Clinical records Previously cited 8/22/24, 6/10/24, 4/25/24, 3/15/24, 1/27/24 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing service Previously cited 8/22/24, 6/10/24, 4/25/24, 3/15/24, 1/27/24		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765 Based on review of clinical records, hospital records, and interviews with resident and staff, it was determined that the facility failed to provide adequate supervision and assistance, resulting in harm from a fall which led to hospitalization and further surgical procedures and treatments for one of the 19 residents reviewed (Resident 20). Findings include: Clinical records review revealed Resident 20 was admitted to the facility on [DATE], with a diagnosis of post-right below knee amputation, Osteomyelitis (bone infection), and left trans metatarsal (foot bone) amputation. Review of Resident 20's admission Minimum Data Set (MDS-standardized assessment tool that measures health status in long-term care residents) dated October 21, 2024, revealed the resident was cognitively intact. The same MDS assessment revealed that the resident required partial/moderate assistance with toilet transfers. Review of Resident 20's care plan developed on October 18, 2024, revealed an ADL (activities of daily living) care plan for the resident requiring assistance/dependent for ADL care with bathing, grooming, dressing, bed mobility, transfer, and toileting. An intervention initiated on October 18, 2024, revealed: Provide two persons assist with toilet transfer and toileting hygiene. Review of the nursing progress notes dated October 21, 2024, at 5:23 p.m., revealed Resident 20 was sent to the hospital post-fall. The same note revealed Resident 20 was transferring over to the toilet with the NA (nurse assistant) when he/she fell and hit the right leg causing surgical incision to open. The same note revealed There was a copious amount of bleeding, a pressure dressing applied, and then sent to the hospital for evaluation. Review of the physician's progress notes dated October 21, 2024, revealed resident was seen for an acute visit regarding a witnessed fall reported with an NA. The same note revealed the Resident stated that he/she was still having a hard time coping with the new right BKA (Below Knee Amputation) and did attempt to use the right leg with the transfer, causing him/her to land on his/her new BKA incision. The right BKA incision split open with profuse bright red blood present and actively bleeding. Pressure dressing was applied immediately and they advised nursing to send the resident to the emergency room for evaluation and repair of the open incision. Review of the hospital record section titled, History and Physical, dated October 21, 2024, revealed patient with post-BKA on October 15, 2024, was sent back to the ED (Emergency Department) after sustaining a fall during transfer from the commode, resulting in right BKA stump injury. The same note revealed, usually he/she has two staff members helping him/her but today it was only one. The BKA surgical site was reported to be open and bleeding at the rehab. The diagnosis was right BKA wound dehiscence with bleeding secondary to mechanical trauma. (continued on next page)		

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 20's hospital records, including Details of Hospital Stay dated October 29, 2024, revealed the patient was admitted and vascular surgery was consulted. The patient was sent to the OR (operating room) for BKA washout and wound vac (wound treatment that uses suction to help wounds heal) placement on October 23, 2024. Post-op, the patient had to be transfused with 1 unit of PRBC (pack red blood cell) due to a drop of the Hgb. He/she experienced acute urinary retention postoperatively requiring multiple straight catheters (A procedure that uses a flexible tube to drain urine from the bladder). The patient developed bleeding from the wound vac so he/she was given another unit of PRBC. Interview conducted with Resident 20 on January 13, 2025, at 10:30 a.m., revealed a few days after he/she was admitted to the facility, a male staff assisted him/her from the wheelchair to the toilet commode. Resident 20 reported it was always two people assisting with transfers but at that moment there was only one. The resident stated He/she thought he/she could handle me by him/herself. The resident further reported he/she lost balance during the transfer and fell hitting the right knee. Interview with the Director of Nursing (DON) conducted on January 15, 2025, at 1:00 p.m., confirmed there was only one person that transferred the resident during the fall. The facility failed to provide Resident 20 with adequate supervision and assistance during toilet transfers resulting in harm from falling including hospitalization , and undergoing additional surgical treatment complications post-surgical procedure. 28 Pa. Code 201.14(a) Responsibility of licensee Previously cited 8/22/24, 4/25/24, 3/15/24, 12/19/23, 5/18/23 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management Previously cited 8/22/24, 4/25/24, 3/15/24, 1/27/24, 12/19/23, 11/1/23, 5/18/23 28 Pa. Code 211.5(f) Clinical records Previously cited 8/22/24, 6/10/24, 4/25/24, 3/15/24, 1/27/24, 5/18/23 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing service Previously cited 8/22/24, 6/10/24, 4/25/24, 3/15/24, 1/27/24, 12/19/23, 11/1/23, 5/18/23		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **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 obtain baseline weight and re-weight for significant weight change for two of the 19 residents reviewed (Resident 28 and 105). Findings include: A review of the facility's policy titled Weight Assessment and Intervention, revised in March 2022, revealed that residents are weighed upon admission and at intervals established by the interdisciplinary team. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. A review of Resident 28 clinical records revealed resident was admitted to the facility on [DATE]. The diagnosis list includes acute respiratory failure (a life-threatening condition where the lungs cannot adequately exchange oxygen and carbon dioxide, leading to low blood oxygen levels), dysphagia (difficulty in swallowing), and moderate protein-calorie malnutrition. Hospital records review dated December 2, 2024, revealed a weight of 115 pounds. A review of Resident 28's weights revealed a baseline admission weight of 152 pounds taken on December 8, 2024, but was struck out by the dietitian, licensed Employee E3. An interview with Employee E3 on January 15, 2025, at 1:00 p.m., revealed the baseline weight was struck out due to discrepancy since the recorded hospital weight was 115 pounds, a re-weight was requested. Clinical records review revealed that re-weight was not done until December 11, 2024, three days after the discrepancy was noted. Resident 28's re-weigh was 140.2 pounds, (7.76%) loss from the baseline weight. The weight result was struck out by Employee E3. Interview with Employee E3 on January 15, 2025, at 1:00 p.m. revealed Employee E3 provided no reason why the re-weight was struck out, re-weight was not done. A review of Resident 28's weight dated December 18, 2024, revealed a weight of 101.8 pounds, an 11.48% weight loss from the hospital. The resident was ordered a magic cup (fortified ice cream). An interview with Employee E3 conducted on January 15, 2025, at 1:00 p.m., confirmed that the resident's re-weights for confirmation were not done timely which delayed interventions to prevent further weight loss. A review of Resident 105's clinical records revealed resident was admitted to the facility on [DATE], with a diagnosis of Cerebral Vascular Accident (CVA- An interruption in the flow of blood to cells in the brain), dysphagia, and presence of Gastrostomy tube (GT- A medical device used to provide nutrition to people who cannot obtain nutrition by mouth). (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 105's weight and vitals revealed a baseline weight of 77 pounds hospital. A review of Employee E3's nutritional assessment dated [DATE], revealed weight per hospital was 77 pounds. The resident was frail with moderate-severe muscle wasting at the clavicles, temples, and shoulder. The resident was NPO (nothing per mouth). The same note revealed resident was severely underweight. The enteral feed of Nutren 2.0 30ml/hr x 24 hours for a total volume of 720 ml was made. A review of Resident 105's January 2025, Medication Administration Record, revealed that from January 7, 2025, until January 13, 2025, Nutren 2.0 was administered but failed to reveal if the resident was able to receive the total volume of 720 cc of feeding for 24 hours. An interview with Employee E3 conducted on January 15, 2025, at 1:00 p.m., confirmed that hospital weight should have not been used as the resident's baseline. Employee E6 was unable to provide an answer as to why Resident 105's baseline weight was not taken when admitted on [DATE]. Employee E3 also confirmed that the total volume of feed received should have been documented to determine if the resident was able to get appropriate nutrition. The facility failed to ensure re-weight was timely done for Resident 28, and baseline weight was done for Resident 105 for appropriate and timely nutritional interventions, monitoring, and treatments. 28 Pa. Code 211.10(d) Resident Care Policies Previously cited 8/22/24, 3/15/24 28 Pa. Code 201.14(a) Responsibility of licensee Previously cited 8/22/24, 4/25/24, 3/15/24 28 Pa. Code 211.5(f) Clinical records Previously cited 8/22/24, 6/10/24, 4/25/24, 3/15/24, 1/27/24 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing service Previously cited 8/22/24, 6/10/24, 4/25/24, 3/15/24, 1/27/24		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 46166 Based upon review of staffing records and performance reviews it was determined the facility failed to ensure performance reviews were completed for five of five staffing records reviewed, (E8, E9, E10, E11, E12). Findings include: Review of staffing records and performance reviews revealed five staff members, E8, E9, E10 E11 and E12, did not have annual performance reviews performed within the appropriate timeframe. Interview with the DON on January 17, 2025, at 2:27 p.m. confirmed staff performance reviews were not completed timely. 28 Pa. Code 201.20(a)(c) Staff Development Previously sited 3/15/24		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 41765 Based on clinical record review and staff interview, it was determined that the facility failed to provide appropriate indication and consistently attempt a non-pharmacological intervention before administering anti-anxiety medication for one of five residents reviewed (Resident 46). Findings include: A review of Resident 46's diagnosis list includes traumatic brain injury (an injury to the brain caused by an external physical force, such as a blow, bump, fall, or hit to the head), anxiety disorder, and depression. A review of Resident 46 physician order dated December 10, 2024, revealed an order of Clonazepam (An anti-anxiety medication) 1 mg (milligram), give one tablet every eight hours as needed for anxiety. A review of Resident 46's December 2024, Medication Administration Record (MAR) revealed that from December 10, 2024, until December 31, 2024, Resident 46 was administered with as-needed Clonazepam 27 times for anxiety. Further review of the same MAR revealed that out of 27 times, as needed Clonazepam was administered 27 times with no appropriate indication except for anxiety. MAR also revealed that medication was administered 19 times without attempts to provide a non-pharmacological intervention before giving the medication. The above was discussed with the Director of Nursing on January 16, 2025, at 1:00 p.m. The facility failed to ensure Resident 46 was provided with appropriate indication and non-pharmacological interventions before administering an anti-anxiety medication. 28 Pa. Code 211.5(f) Clinical records Previously cited 8/22/24, 6/10/24, 4/25/24, 3/15/24, 1/27/24 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing service Previously cited 8/22/24, 6/10/24, 4/25/24, 3/15/24, 1/27/24		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41765 Based on a review of the facility's policy, and drug manufacturer's recommendations, observations, and staff interviews, it was determined that the facility failed to ensure medications were properly stored and labeled for two of four medication carts reviewed (1 East medication cart 1 and 2). Findings include: A review of the facility policy titled Medication Labeling and Storage, revised in February 2023, revealed that medications and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. The same policy indicated that multi-dose vials that have been opened or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. A review of the manufacturer's storage guidelines for Insulin Lispro (Humalog-fast-acting insulin), revealed that the medication must be stored at room temperature and must be discarded within 28 days after opening. A review of the manufacturer's storage guidelines for Insulin Aspart (Novolog-fast-acting insulin), revealed that the medication must be stored at room temperature and must be discarded within 28 days after opening. A review of the manufacturer's storage guidelines for Insulin Degludec (A long-acting insulin), revealed that after first use, insulin can be stored at room temperature or in the refrigerator without the needle attached for a maximum of eight weeks. An observation of the 1East medication cart 1 was conducted on January 14, 2025, at 9:21 a.m., in the presence of licensed nurse Employee E4. The following were observed: 18 long white tablets in a medication cup; 72 Mucinex tablets (A cough medication); 24 Simethicone medication (A medication that treats symptoms of gas, like feeling full, pressure, and bloating); 17 Imodium (Anti-diarrhea medication); and nine Bisacodyl suppositories (A medication to treat constipation). All mentioned medications were observed on the top drawer of the medication cart without their original container/package. Further observation revealed two Lispro insulin pens, opened and used but undated. An interview with Employee E4 conducted on January 14, 2025, at 9:30 a.m., confirmed that medications should be in their original container. Employee E4 also confirmed that insulin pens should have been dated once opened. Employee E4 further reported that the long white tablets in a medication cup were Tylenol (A medication to treat mild pain) as reported by the outgoing shift nurse. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation of the 1East medication cart 2 was conducted on January 14, 2025, at 9:35 a.m., in the presence of licensed nurse Employee E5. The following were observed: five loose Xarelto tablets (An ant-coagulant medication), 15 tablets of Mucinex; and five Bisacodyl suppositories. The medications were not in their original containers/packages. Also observed were three Degludec insulin pens, opened and undated; one Lispro insulin pen, opened and undated; one Aspart insulin pen, opened and undated, and one Lispro insulin vial, opened and undated. Interview with Employee E5 conducted on January 14, 2025, at 9:40 a.m., confirmed medications should be on their original container/package and insulins should have been dated when opened. The above was discussed with the Director of Nursing on January 16, 2025, at 10:00 a.m. The facility failed to ensure medications on 1East medication carts 1 and 2 were properly stored and labeled. 28 Pa. Code 201.14(a) Responsibility of licensee Previously cited 8/22/24, 4/25/24, 3/15/24 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management Previously cited 8/22/24, 4/25/24, 3/15/24, 1/27/24 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing service Previously cited 8/22/24, 6/10/24, 4/25/24, 3/15/24, 1/27/24		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50032 Based on review of facility's policy, observations and staff interviews, it was determined the facility failed to ensure infection control was practiced for a resident with COVID and Enhanced Barrier Precautions (infection control prevention designed to reduce transmission of MDRO-multidrug-resistant organisms in nursing homes) were in place for residents requiring enhanced barrier precautions for seven of seven residents reviewed (Resident 8, 13, 20, 21, 30, 46, and 105). Findings include: Review of the facility's current Enhanced Barrier Precautions policy as revised by the facility dated March 2024, revealed for residents for whom EBP are indicated, EBP is employed when performing high contact resident care activities. This includes the use of gown and gloves for the use of accessing wound care (any skin opening requiring a dressing). Review of Resident 8's clinical record revealed, Resident was admitted on [DATE], with a diagnosis of Partial Traumatic Amputation of Right Foot, Level Unspecified, Subsequent Encounter (part of the foot has been severed due to an injury or trauma but not the entire foot) and Type 2 Diabetes with Diabetic Peripheral Angiopathy with Gangrene (condition that occurs with type 2 diabetes that develops peripheral arterial disease that leads to gangrene) Observation of Resident 8 on January 13, 2025 @ 09:41 am revealed bilateral (left and right) feet wrapped in gauze with toes open to air and post-op boots in place. Observation of Resident 8's room on all four days of the survey failed to reveal evidence of EBP signage or PPE. Review of Resident 13's clinical record revealed, Resident was admitted on [DATE], with a diagnosis of Pressure Ulcer of Sacral Region, Unspecified Stage and Unspecified Open Wound of Lower Back and Pelvis Without Penetration into Retroperitoneum, Initial Encounter (a pressure sore located on the tailbone where the exact stage of the wound is unknown, along with an open wound on the lower back and pelvis that does not extend deep enough to reach the tissue behind the abdominal lining). Interview with licensed staff Employee E7 on January 14, 2025, revealed that Resident 13 Stage 3 sacral wound had primarily healed and that dressing changes were no longer required however per clinical record wound treatment continued daily and PRN (as the need arises). Observation of Resident 13's room on all four days of the survey failed to reveal evidence of EBP signage or PPE. Clinical records review revealed Resident 20 has surgical wound to the right leg post below knee amputations. Observations conducted on January 13, 2025, at 10:00 a.m., revealed a dressing to Resident 20's right knee. Additional observation revealed absence of EBP signage/communication. There was no PPE available outside of the resident's room. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 21's clinical record revealed, Resident was admitted on [DATE], with a diagnosis of Encounter for Other Orthopedic Aftercare (routine follow-up care by a healthcare provider after orthopedic surgery on a joint or bone) and Type 2 Diabetes Mellitus with Unspecified Complications (a diagnosis of type 2 diabetes where the specific complications are not yet identified), Resident 21 is receiving treatment for an arterial wound to second digit left foot. Observation of Resident 21 on January 13, 2025 @ 10:00 am revealed resident in bed with bilateral foam boots and left foot wrapped with Kling (stretchy -gauze material that is wrapped around a wound or injury). Observation of Resident 21's room on all four days of the survey failed to reveal evidence of EBP signage or PPE. Clinical records review revealed Resident 30 has a Gastrostomy tube (GT- A medical device used to provide nutrition to people who cannot obtain nutrition by mouth). Observation conducted on January 13, 2025, at 10:15 a.m., revealed absence of EBP signage/communication. There was no PPE available outside of the resident's room Clinical records review revealed Resident 46 has a GT. Observation conducted on January 13, 2025, at 10:30 a.m., revealed absence of EBP signage/communication. There was no PPE available outside of the resident's room. Observation of Resident 8, 13 And 21's room on all four days of the survey failed to reveal personal protective equipment located outside the room or signage indicating Resident 8,13, and 21 were on Enhanced Barrier Precautions. Interview with the Director of Nursing on January 16, 2024, at 12:30 pm confirmed that Resident 8, 13 & 21were not on Enhanced Barrier Precautions at the time of the survey despite meeting the above criteria. Clinical records review revealed Resident 105 was on transmission-based precaution for diagnosis of COVID (An infectious disease caused by SARS-CoV-2). An observation conducted on Resident 105's room on January 14, 2025, at 12:48 p.m., in the presence of licensed employee E5 revealed absence of bin/container for used PPE (personal protective equipment). Observations also revealed the following: one yellow gown on the bathroom floor, one yellow gown hanged on the toilet handrail; used glove on the bathroom floor, and two used gloves on top of the drawer. The above was discussed with the Director of Nursing on January 16, 2025, at 10:00 a.m. 28 Pa. Code 201.14(a) Responsibility of licensee Previously cited 8/22/24, 4/25/24, 3/15/24 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management Previously cited 8/22/24, 4/25/24, 3/15/24, 1/27/24 (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

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