STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395351	A. BLDG: 00 B. WING:	12/10/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WEST READING SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **902202**	**425 BUTTONWOOD STREET WEST READING, PA 19611**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification survey, State Licensure survey, and a Civil Rights Compliance survey completed on December 10, 2024, it was determined that West Reading Skilled Nursing and Rehabilitation Center, was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0623 SS=C		F 0623		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0623 SS=C	Continued from page 1 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)	F 0623	1. Residents 39, 85, 89, 94, 143, 146 and 157, their responsible party, or legal representative were provided with the facility Transfer notice. 2 .An initial audit will be completed by the NHA/Designee on residents that have been transferred out of the facility to an acute care facility since 12/10/24 have been reviewed to ensure their responsible party, or legal representative, was provided with the Transfer notice. 3. Licensed nursing staff will be re-educated on the Discharge/Transfer Policy and process by the DON and/or Designee. Residents transferred out of the facility will be reviewed at clinical meeting to ensure the RP has been provided with the transfer notice 4. The NHA and/or designee will complete a random weekly audit x 90 days of Residents who have transferred to the hospital to ensure transfer notices were provided to them, their responsible party, or legal representative. Results of the audit will be reported to the Quality	Completion Date: **01/23/2025** Status: **APPROVED** Date: **12/24/2024**

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F 0623 SS=C	Continued from page 2 (1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 0623	Assurance Performance Improvement Committee monthly.	

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F 0623 SS=C	Continued from page 3 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by:	F 0623		

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F 0623 SS=C	Continued from page 4 Based on clinical record review and staff interview, it was determined that the facility failed to notify the resident and the resident's representative(s) of transfer(s) from the facility, including the reasons for the moves and Ombudsman information, in writing upon transfer for eight of eight sampled residents who were transferred to the hospital. (Residents 39, 85, 89, 94, 95, 143, 146, 157) Findings include: Clinical record review revealed that Resident 39 was transferred to the hospital on October 25 and November 7, 2024, after changes in condition. There was no documentation to support that the resident or the resident's responsible party or legal representative was provided written information regarding the transfers to the hospital. Clinical record review revealed that Resident 85 was transferred to the hospital on July 9, September 1 and 13, and October 2, 2024, after changes in condition. There was no documentation to support	F 0623		

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F 0623 SS=C	Continued from page 5 that the resident or the resident's responsible party or legal representative was provided written information regarding the transfers to the hospital. Clinical record review revealed that Resident 89 was transferred to the hospital on November 3, 2024, after a change in condition. There was no documentation to support that the resident or the resident's responsible party or legal representative was provided written information regarding the transfer to the hospital. Clinical record review revealed that Resident 94 was transferred to the hospital on August 23, 2024, after a change in condition. There was no documentation to support that the resident or the resident's responsible party or legal representative was provided written information regarding the transfer to the hospital. Clinical record review revealed that Resident 95 was transferred to the hospital on July 7, 2024, after a change in condition. There was no documentation	F 0623		

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F 0623 SS=C	Continued from page 6 to support that the resident or the resident's responsible party or legal representative was provided written information regarding the transfer to the hospital. Clinical record review revealed that Resident 143 was transferred to the hospital on November 2, 2024, after a change in condition. There was no documentation to support that the resident and/or the resident's responsible party or legal representative was provided written information regarding the transfer to the hospital. Clinical record review revealed that Resident 146 was transferred to the hospital on December 4, 2024, after a change in condition. There was no documentation to support that the resident or the resident's responsible party or legal representative was provided written information regarding the transfer to the hospital. Clinical record review revealed that Resident 157 was transferred to the hospital on September 11, 2024, after a change in condition. There was no	F 0623		

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F 0623 SS=C	Continued from page 7 documentation to support that the resident and/or the resident's responsible party or legal representative was provided written information regarding the transfer to the hospital. In an interview on December 10, 2024, at 9:45 a.m., the Administrator confirmed that residents and/or resident representatives were not given written notice regarding transfers from the facility. CFR 483.15(c)(3) Notice before transfer Previously cited 1/25/24	F 0623		
F 0656 SS=D		F 0656		

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F 0656 SS=D	Continued from page 8 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	1. Care Plans for Residents 16, 48, 132 , 143 were reviewed and updated. 2. An audit of current residents Care Plans of all residents that have sacral wound, indwelling catheter, foley, pain will be reviewed to ensure they include a comprehensive plan of care with interventions that are individualized for each resident. 3. Licensed Nursing staff will be re-educated on the importance of reviewing and updating care plans and areas identified through the Care Assessment Area are completed in the resident care plan. 4. The DON and/or designee will complete weekly random audits x 90 days on five resident Care Plans to ensure areas identified in the CAA are contained on the resident care plan. Results of the audit will be reported to the Quality Assurance Performance Improvement Committee monthly.	Completion Date: **01/23/2025** Status: **APPROVED** Date: **12/26/2024**

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F 0656 SS=D	Continued from page 9 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656		

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F 0656 SS=D	Continued from page 10 Based on clinical record review and staff interview, it was determined that the facility failed to develop a comprehensive care plan that addressed individual resident needs as identified in the comprehensive assessment for four of 32 sampled residents. (Residents 16, 48, 132, 143) Findings include: Clinical record review revealed that Resident 16 had diagnoses that included pressure ulcer of the sacral region. The Minimum Data Set (MDS) assessment dated September 12, 2024, noted that the resident had a pressure area. The MDS Care Area Assessment (CAA) summary dated September 12, 2024, noted that the resident's pressure area was to be addressed in the care plan. There was no evidence that interventions to address Resident 16's pressure area were included in the current care plan. Clinical record review revealed that Resident 48 had diagnoses that included obstructive uropathy (build up of excess urine in the kidneys). The MDS	F 0656		

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F 0656 SS=D	Continued from page 11 assessment dated September 19, 2024, noted that the resident had an indwelling catheter. The MDS CAA summary dated September 19, 2024, noted that the resident's indwelling catheter was to be addressed in the care plan. There was no evidence that interventions to address Resident 48's indwelling catheter were included in the current care plan. Clinical record review revealed that Resident 132 was admitted to the facility on October 28, 2024, and had diagnoses that included neoplasm of the bladder and pancreas, cervicalgia, and migraines. The MDS assessment dated November 4, 2024, noted that the resident received daily scheduled pain medication. The MDS CAA summary dated November 4, 2024, noted that the resident's pain was to be addressed in the care plan. There was no evidence that interventions to address Resident 132's pain were included in the current care plan. Clinical record review revealed that Resident 143 was admitted to the facility on July 12, 2024, and	F 0656		

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F 0656 SS=D	Continued from page 12 had diagnoses that included acute cerebrovascular insufficiency, cellulitis, and psoriasis. The MDS assessment dated November 14, 2024, noted that the resident was frequently incontinent. The MDS CAA summary dated July 19, 2024, noted that the resident's urinary incontinence was to be addressed in the care plan. There was no evidence that interventions to address Resident 143's urinary incontinence were included in the current care plan. In an interview on December 10, 2024, at 11:44 a.m., the Director of Nursing confirmed the above care areas were not addressed in the care plans. CFR 483.21(b)(1) Comprehensive Care Plans Previously cited 1/25/2024 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0656		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 13 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	1. Resident 16's is receiving Midodrine according to physician orders. Resident 56 is being weighed according to physician orders. 2. An initial audit will be completed by the Director of Nursing/Designee on current residents with Midodrine orders to ensure they are receiving medication according to physician orders. An initial audit will be completed by the Director of Nursing/Designee on current residents to ensure weights completed according to facility policy or physician orders. 3. Licensed Nursing staff will be re-educated on following physician's orders with special attention to orders with parameters and weights. 4. The DON/designee will complete weekly random audits to ensure weights are completed according to facility policy or physician orders.Results of the audit will be reported to the Quality Assurance Performance Improvement Committee monthly.	Completion Date: **01/23/2025** Status: **APPROVED** Date: **12/27/2024**

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F 0684 SS=D	Continued from page 14 Based on clinical record review and staff interview, it was determined that the facility failed to implement physician's orders for two of 32 sampled residents. (Residents 16, 56) Findings include: Clinical record review revealed that Resident 16 had diagnoses that included hypotension (low blood pressure). A physician's order dated June 7, 2024, directed staff to administer a medication (midodrine) three times a day every Monday, Wednesday, and Friday for hypotension. Staff were not to administer the medication if the resident's systolic blood pressure (SBP, the first measurement of blood pressure when the heart beats and the pressure is at its highest) was greater than 130 millimeters of mercury (mmHg). Review of Resident 16's medication administration records (MARs) revealed that staff administered the medication seven times in November and four times in December 2024 when the resident's SBP was greater than 130 mmHg.	F 0684		

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WEST READING SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **902202**	**425 BUTTONWOOD STREET WEST READING, PA 19611**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0684 SS=D	Continued from page 15 Clinical record review revealed that Resident 56 had diagnoses that included cerebral infarction (sudden loss of blood flow to the brain), chronic kidney disease, and chronic osteomyelitis (bone infection). A physician's order dated October 29, 2024, directed staff to weigh the resident weekly on Tuesday for four weeks, then monthly. A review of the MAR revealed that there was no evidence that staff weighed Resident 56 as ordered on November 5, 19, and 26, 2024. In an interview on December 10, 2024, at 10:05 a.m., the Director of Nursing confirmed that the medication was administered outside of the established parameters for Resident 16 and that there was no documented evidence that Resident 56 was weighed as ordered. CFR 483.25 Quality of care Previously Cited 1/25/24 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0684		

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F 0684 SS=D	Continued from page 16	F 0684		
F 0689 SS=D		F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0689 SS=D	Continued from page 17 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	Resident 146 has safety interventions in place to prevent falls. Physician has been notified of any fall. An initial audit will be completed by the Director of Nursing/Designee on current residents who have fallen have been reviewed to ensure safety interventions were put in place and physicians have been notified of the fall. Licensed Nursing staff will be re-educated on following up to ensure fall interventions are in place including documentation as needed and notification of physician. Resident falls will be reviewed at clinical meetings to ensure safety interventions are implemented and physicians are notified when a fall occurs. DON/designee will conduct a weekly random audit on five resident falls x 90 days to ensure safety interventions were implemented and physician was notified. Results of the audit will be reported to the	Completion Date: **01/23/2025** Status: **APPROVED** Date: **12/26/2024**

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F 0689 SS=D	Continued from page 18	F 0689	Quality Assurance Performance Improvement Committee monthly.	

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F 0689 SS=D	Continued from page 19 Based on facility policy review, clinical record review, review of facility documentation, and staff interview, it was determined that the facility failed to ensure that safety interventions were implemented to prevent falls and that the physician was notified per facility policy for one of 32 sampled residents. (Resident 146) Findings include: Review of the facility policy entitled, "Accidents/Incidents," last reviewed November 15, 2024, revealed that staff was to investigate all accidents and implement appropriate interventions based on conclusions, and that the physician would be notified of any unwitnessed fall. Clinical record review revealed that Resident 146 was admitted to the facility on October 8, 2024, with diagnoses that included hemiplegia and hemiparesis (paralysis), and altered mental status. Review of the Minimum Data Set assessment dated November 18, 2024, revealed that the resident had	F 0689		

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F 0689 SS=D	Continued from page 20 cognitive impairment. Review of the care plan revealed Resident 146 was at risk for falls due to cognitive loss and lack of safety awareness. Review of facility documentation revealed that Resident 146 had unwitnessed falls on October 22, November 1, 8, 14, 20, and December 7, 2024, and no additional interventions were put into place. On November 3, 2024, Resident 146 had a fall with an intervention for a bowel and bladder assessment, and on November 15, 2024, with an intervention for safety checks every 15 minutes. There was no documented evidence that a bowel and bladder assessment was completed or that safety checks were put into place. There was no documented evidence that the physician was notified of the fall on November 20, 2024. In an interview on December 10, 2024, at 11:45 a.m., the Director of Nursing confirmed that there were no safety interventions initiated after the falls, and that there should have been. The Director of Nursing also confirmed that there was no bowel and bladder assessment completed, or safety checks	F 0689		

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F 0689 SS=D	Continued from page 21 implemented, and that the physician was not notified of the fall on November 20, 2024. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0689		
F 0732 SS=C	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and	F 0732	1&2 The accurate and current nurse staffing information is now posted daily. 3.Nurse supervisors and Scheduler/payroll Manager will be re-educated by the NHA on posting accurate and current nurse staffing information daily. 4. The NHA and/or designee will complete weekly random audits x 90 days of posted nurse staffing information. Results of the audit will be reported to the Quality Assurance Performance Improvement Committee monthly	Completion Date: **01/23/2025** Status: **APPROVED** Date: **12/26/2024**

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F 0732 SS=C	Continued from page 22 visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:	F 0732		

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F 0732 SS=C	Continued from page 23 Based on observation and interview, it was determined that the facility failed to post accurate and current nurse staffing information. Findings include: During a tour of the facility conducted on December 8, 2024, at 9:05 a.m., the staffing information that was posted in the lobby was dated for December 6, 2024. In an interview on December 10, 2024, at 10:00 a.m., the Administrator confirmed that incorrect staffing data was posted. 28 Pa Code 201.18(b)(3) Management.	F 0732		
F 0756 SS=D		F 0756		

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F 0756 SS=D	Continued from page 24 483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 0756	Residents 79 & 149 pharmacy recommendations have been reviewed by the physician. An initial audit will be completed by the Director of Nursing/Designee on Pharmacy recommendations since 11/1/24 to ensure recommendations have been reviewed by the MD/CRNP and recommendations followed in a timely manner. Licensed Nursing staff will be re-educated by the Director of Nursing or designee on ensuring pharmacy recommendations are reviewed with MD/CRNP and followed up on in a timely manner. The DON and/or designee will complete weekly random audits x90 days on pharmacy recommendations to ensure they were followed up on. Results of the audit will be reported to the Quality Assurance Performance Improvement Committee monthly.	Completion Date: **01/23/2025** Status: **APPROVED** Date: **12/26/2024**

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F 0756 SS=D	Continued from page 25 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 0756		

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F 0756 SS=D	Continued from page 26 Based on clinical record review, and staff interview, it was determined that the facility failed to ensure that pharmacy recommendations were acted upon in a timely manner for two of 32 sampled residents. (Residents 79, 149) Findings include: Clinical record review revealed that Resident 79 was admitted to the facility on October 13, 2023, with diagnoses that included Parkinsonism, dementia, and depression. Review of the clinical record revealed that the pharmacist made recommendations regarding Resident 79's medications on June 19, July 26, August 19, September 17, October 28, and November 30, 2024. There was no documentation to indicate what the recommendations were for June, July, August, or September, or that they were addressed by the physician. Clinical record review revealed that Resident 149 was admitted to the facility on September 20, 2024	F 0756		

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F 0756 SS=D	Continued from page 27 with diagnoses that included syncope and collapse (fainting), hypertension (high blood pressure), and dementia. Review of the clinical record revealed that the pharmacist made recommendations regarding Resident 149's medications on September 25 and November 12, 2024. There was no documentation regarding what the recommendations were for September and November or that they were addressed by the physician. In an interview on December 10, 2024, at 11:40 a.m., the Director of Nursing confirmed that there was no documentation regarding specific pharmacy recommendations or that they were acted upon in a timely manner. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.	F 0756		
F 0761 SS=D		F 0761		

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F 0761 SS=D	Continued from page 28 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	1. The four insulin pens that were opened were not dated, the TB vaccine in the refrigerator opened and not dated, the three bottles of expired doxycycline, and outdated Glycerin suppositories were all removed and disposed of per policy. 2.An initial audit will be completed by the Director of Nursing/Designee on Medication refrigerator, carts and medication rooms to ensure medications are stored and labeled appropriately. 3. Licensed Nursing staff will be re-educated by the director of nursing or designee on the facility "Storage of medication" policy. 4. Unit Managers/RN Supervisors will conduct weekly random audits x 90 days med carts and med rooms to assure medications are stored and labeled appropriately Results of the audit will be reported to the Quality Assurance Performance Improvement	Completion Date: **01/23/2025** Status: **APPROVED** Date: **12/26/2024**

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F 0761 SS=D	Continued from page 29	F 0761	Committee monthly.	

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F 0761 SS=D	Continued from page 30 Based on a review of facility policy, observation, and staff interview, it was determined that the facility failed to properly store medications in one of three nursing units. (Second Floor Nursing Unit) Findings include: Review of the facility policy entitled, "Storage of Medication," last reviewed November 15, 2024, revealed that staff were to note the date on the label for insulin vials and pens when first opened. Outdated, contaminated, discontinued, or deteriorated medications were to be immediately removed from stock and disposed of according to procedures for medication disposal. Observation of a medication cart used for resident rooms 218 through 229 on December 9, 2024, revealed four insulin lispro pens that were opened and not labeled, one insulin glargine pen that was opened and not labeled, one Semglee insulin pen that was opened and not labeled, and one Basaglar insulin pen that was opened and not labeled. In an	F 0761		

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F 0761 SS=D	Continued from page 31 interview, the licensed practical nurse 1 (LPN 1) stated that the insulin pens should have been labeled with an open date. Observation of the medication storage room refrigerator on the second floor nursing unit on December 9, 2024, revealed one vial of Tubersol that was opened and not labeled, in a storage box labeled discard by October 5, 2024. There were three bottles of doxycycline labeled do not use after September 20, 2024. There was a large container of glycerin suppositories labeled for a resident who had expired September 2, 2023. In an interview, on December 10, 2024, at 9:45 a.m., the Director of Nursing stated that the staff was to label all medications with open and expiration dates and all expired or discontinued medication was to be removed from the medication cart and medication storage room refrigerator. 28 Pa. Code 211.12 (d)(1)(2)(5) Nursing services.	F 0761		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WEST READING SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **902202**	**425 BUTTONWOOD STREET WEST READING, PA 19611**

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F 0761 SS=D	Continued from page 32	F 0761		
F 0801 SS=E		F 0801		

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F 0801 SS=E	Continued from page 33 483.60(a)(1)(2) Qualified Dietary Staff §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered	F 0801	1&2. The current dietary manager is scheduled to complete Dietary Manager Training coursework to obtain certification by 6/27/25. Nutraco continues efforts to hire a FT RD while supporting needs remotely. In addition a job requisition was posted for FT RD at West Reading. 3. Re-educated was completed to the NHA on the requirements of 0801. 4. NHA or designee will complete an initial audit x 90 days of the credentials of the newly hired Registered Dietitian to ensure compliance with 0801. Results of the audit will be reported to the Quality Assurance Performance Improvement Committee monthly.	Completion Date: **01/23/2025** Status: **APPROVED** Date: **12/26/2024**

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F 0801 SS=E	Continued from page 34 dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State	F 0801		

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F 0801 SS=E	Continued from page 35 requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by:	F 0801		

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F 0801 SS=E	Continued from page 36 Based on staff interview, it was determined that the facility failed to employ a full-time qualified dietary services manager in the absence of a full-time qualified dietitian. Findings include: During an interview on December 8, 2024, at 11:00 a.m., the dietary manager stated the facility did not employ a certified dietary manager. In an interview conducted on December 10, 2024, at 11:30 a.m., the Administrator confirmed that there was not a full-time dietitian employed onsite at the facility and that the facility did not employ a qualified certified dietary manager in the absence of a full-time dietitian. 28 Pa. Code 201.18(b)(3) Management.	F 0801		

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F 0803 SS=E	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by:	F 0803	1&2 The pre-approved menus will be followed if not, residents will be notified of substitutions via announcement & the daily posted menu. 3. The Director of Dining Services and dietary staff will be educated on following pre-approved menus, if substitutions are made, the residents will be notified via announcement & the daily posted menu. 4. The NHA and/or designee will complete weekly random audits x 90 days of posted menus and the substitution logs to ensure residents were notified. Results of the audit will be reported to the Quality Assurance Performance Improvement Committee monthly.	Completion Date: **01/23/2025** Status: **APPROVED** Date: **12/26/2024**

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F 0803 SS=E	Continued from page 38 Based on resident interview, review of facility documentation, observation, and staff interview, it was determined that the facility failed to follow the pre-approved menus. (Residents 16, 22, 208) Findings include: During the Resident Council interview conducted on December 9, 2024, at 10:30 a.m., four of four residents stated that food items at meals were often substituted without notice. Review of the facility menus revealed the lunch meal on December 8, 2024, was to include roasted potatoes, dinner roll, and fruit pie. The lunch meal on December 9, 2024, was to include fruit ambrosia salad. Observation of Resident 16 and Resident 208's lunch meal ticket on December 8, 2024, at 1:10 p.m., revealed that the meal should have included roasted potatoes, a dinner roll, and fruit pie. The residents received mashed potatoes, fruit ambrosia	F 0803		

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F 0803 SS=E	Continued from page 39 salad, and no dinner roll. On December 9, 2024, at 12:55 p.m., Resident 16 and Resident 22's meal ticket revealed that the meal should have included fruit ambrosia salad and the residents received applesauce. In an interview on December 10, 2024, at 9:30 a.m., the Dietary Manager reported the previously mentioned items were not served as planned on the facility menu. 28 Pa. Code 211.6(a) Dietary services.	F 0803		
F 0812 SS=F		F 0812		

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F 0812 SS=F	Continued from page 40 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	1&2. The food items identified that were not dated or expired were discarded; dried food debris on the bottom of the cooler, and top of bulk containers in the food prep area were immediately cleaned when identified; the scoop was removed from the flour container; Ecolab visited when problem was identified and observed that the sanitizer solution was being diluted by water from dish machine which was immediately remediated; the cook verbally educated when problem identified; nursing staff discarded all food that was not properly labelled. 3. Dietary staff was re-educated on dating/labeling of all food and discarding expired food; properly cleaning food debris daily; removing scoop/utensils from food containers; monitoring the dish machine sanitizer level of 50ppm; timely recording of food holding temperatures on the trayline; nursing staff re-educated on properly	Completion Date: **01/23/2025** Status: **APPROVED** Date: **12/26/2024**

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F 0812 SS=F	Continued from page 41	F 0812	labelling of food in resident's pantry refrigerators. 4. The NHA and/or designee will conduct weekly random audit x 90 days of food being stored in coolers to ensure dating is being completed; cleanliness of coolers and food prep areas; containers to ensure utensils aren't left in them; sanitizer logs and random test; trayline food temperature logs are completed; and resident's pantry refrigerators for properly labelled food. Results of the audit will be reported to the Quality Assurance Performance Improvement Committee monthly.	

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F 0812 SS=F	Continued from page 42 Based on facility policy review, staff interview, and observation, it was determined that the facility failed to store food in a sanitary manner in the dietary department and on one of three nursing units. (Nursing unit 2) Findings include: Review of the facility policy entitled, "Food Handling," dated November 15, 2024, revealed that staff were to label food items with the date prepared or opened. At the beginning of each meal service, staff were to obtain tray line holding food temperatures and record them onto the Production Worksheet. Observations during the kitchen tour on December 8, 2024, at 9:23 a.m., revealed the following: In reach-in cooler #1, there were two chef salads, three opened bags of cheddar cheese, lettuce, shredded carrots, and an opened container of diced tomatoes that were not dated. There was dried food	F 0812		

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F 0812 SS=F	Continued from page 43 debris on the bottom of the cooler. In reach-in cooler #2, there was an opened bag of diced potatoes and parmesan cheese that were not dated. In reach-in cooler #3, there were three cups of dished crushed pineapple that were not dated. In reach-in cooler #6, there was an opened package of cinnamon rolls that was not dated. In reach-in cooler #9, there was a container of cottage cheese with a use by date of September 29, 2024, and a carton of whole milk dated October 23. In the reach-in snack cooler, there were three cups of diced peaches that were not dated. In dry storage, there was a large opened bag of dried breadcrumbs on top of a file cabinet. There were bread crumbs on the floor. On the floor below the condiment shelf, there were multiple dried onion peels and paper debris. In the food preparation area, there were three bulk containers of dried milk, thickener, and flour that had food debris covering the lids. In the flour bin, the scoop was in the flour.	F 0812		

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F 0812 SS=F	Continued from page 44 According to the Dietary Manager (DM), the dish machine required a chemical solution to sanitize the dishware. Observations of two chemical strips done at 10:20 a.m., and 10:24 a.m., during dish wash service for breakfast revealed a chemical solution of 10 parts per million (ppm) with the federal regulation being 50 ppm. There was no documented evidence that the tray line holding food temperatures were taken and recorded onto the Production Worksheet since November 12, 2024. In an interview on December 8, 2024, at 11:30 a.m., the DM confirmed that the previously mentioned items should have been dated and the expired items removed. In an interview on December 10, 2024, at 11:45 a.m., the Administrator confirmed that there was no documented evidence that the tray line holding temperatures were taken and recorded on the	F 0812		

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F 0812 SS=F	Continued from page 45 Production Worksheet per policy. Review of the facility policy entitled, " Food Brought in for Residents," dated November 15, 2024, revealed that foods that require refrigeration were to be labelled with the resident's name and the date. Observation of the Nursing unit 2 resident pantry on December 8, 2024, at 11:30 a.m., revealed that there was a beef patty in the freezer that was not dated or labelled. In the refrigerator there was an opened jar of pickles and mustard, a container of pasta with red sauce and soup, a sandwich, a bottle of soda, a bag that had an opened bottle of dressing and two containers of salad, chocolate pudding, and three dishes of pineapple that were not labelled or dated. CFR 483.60(i) Food Safety Requirement Previously cited 1/25/24, 6/28/24 28 Pa. Code 201.14(a) Responsibility of licensee.	F 0812		

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F 0812 SS=F	Continued from page 46 28 Pa. Code 201.18(b)(3)(e)(2.1) Management.	F 0812		
F 0814 SS=C		F 0814		

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F 0814 SS=C	Continued from page 47 483.60(i)(4) Dispose Garbage and Refuse Properly §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by:	F 0814	1&2 Upon notification, the area was immediately cleared of trash and refuse. 3. The Director of Dining Services and dietary staff will be re-educated on maintaining a trash and refuse free dumpster area. 4. The NHA and/or designee will complete weekly random audits x 90 days of the dumpster area to ensure it remains free of trash and refuse. Results of the audit will be reported to the Quality Assurance Performance Improvement Committee monthly.	Completion Date: **01/23/2025** Status: **APPROVED** Date: **12/26/2024**

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F 0814 SS=C	Continued from page 48 Based on observation, it was determined that the facility failed to dispose of trash and refuse properly. Findings include: Observation of the dumpster area on December 8, 2024, at 9:45 a.m., revealed multiple pieces of crushed plastic and cardboard debris, crushed Styrofoam containers, and used gloves around the outside of both dumpsters. One dumpster had two lids on top of it, one of the lids was wide open and the other lid had two full bags of garbage on top of it. 28 Pa Code 201.18(b)(3) Management.	F 0814		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395351	A. BLDG: 00 B. WING:	12/10/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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P 5520	Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	1&2. Education given to the Nurse Scheduler on the Certified Nursing Aides ratio requirements of 1 NA to 10 residents on day shift, 1 NA to 11 residents on evening shift, and 1 NA to 15 residents on night shift.. 3. The facility is actively recruiting Certified Nurses Aides; utilizing Nurse Agency to supplement Certified Nursing Aides; recruiting Nursing Aides for classes and training with intent to hire when qualified; and staffing meetings conducted in attempts to maintain State Mandated ratios for Certified Nursing Aides. 4. The DON and/or designee will randomly audit the staffing schedules to ensure the appropriate number of Certified Nursing Aides are scheduled to achieve compliance. The results of the audits will be submitted to the QA Committee to determine if additional action is necessary.	Completion Date: **01/23/2025** Status: **APPROVED** Date: **12/26/2024**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5520	Continued from page 1 Based on a review of nursing time schedules, it was determined that the facility failed to meet the minimum nurse aide (NA) to resident ratios for 14 of 21 days reviewed. Findings include: Review of nursing schedules for 21 days from September 1 through 7, October 25 through 31, and December 3 through 9, 2024, revealed the following: The facility failed to meet the minimum NA to resident ratio of one NA for ten residents on day shift (7:00 a.m. to 3:00 p.m.) on September 1, 2, 3, 4, 6, and 7, October 26 and 27, and December 7, 2024. The facility failed to meet the minimum NA to resident ratio of one NA for 11 residents on evening shift (3:00 p.m. to 11:00 p.m.) on September 7, October 26, 27, 28, 29, and 31, and December 8 and 9, 2024.	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395351	A. BLDG: __00_____ B. WING: _____	12/10/2024

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P 5520	Continued from page 2 The facility failed to meet the minimum NA to resident ratio of one NA for 15 residents on night shift (11:00 p.m. to 7:00 a.m.) on September 1 and 2, and December 7, 2024.	P 5520		
P 5530		P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 3 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	1&2. Education given to the Nurse Scheduler on the LPN ratio requirements of 1 LPN to 25 residents on day shift, 1 LPN to 30 residents on evening shift, and 1 LPN to 40 residents on night shift.. 3. The facility is actively recruiting LPNs; utilizing Nurse Agency to supplement LPNs; and staffing meetings conducted in attempts to maintain State Mandated ratios for LPNs. 4. The DON and/or designee will randomly audit the staffing schedules to ensure the appropriate number of LPNs are scheduled to achieve compliance. The results of the audits will be submitted to the QA Committee to determine if additional action is necessary.	Completion Date: **01/23/2025** Status: **APPROVED** Date: **12/26/2024**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 4 Based on a review of nursing time schedules, it was determined that the facility failed to meet the minimum licensed practical nurse (LPN) to resident ratios for four of 21 days reviewed. Findings include: Review of nursing schedules for 21 days from September 1 through 7, October 25 through 31, and December 3 through 9, 2024, revealed the following: The facility failed to meet the minimum LPN to resident ratio of one LPN for 25 residents on day shift (7:00 a.m. to 3:00 p.m.) on October 27, 2024. The facility failed to meet the minimum LPN to resident ratio of one LPN for 30 residents on evening shift (3:00 p.m. to 11:00 p.m.) on December 4 and 7, 2024. The facility failed to meet the minimum LPN to resident ratio of one LPN for 40 residents on night	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 5 shift (11:00 p.m. to 7:00 a.m.) on September 7, 2024.	P 5530		
P 5640	Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	1&2. Education given to the Nurse Scheduler on the PPD requirements of 3.2 hours of direct care for each resident. 3. The facility is actively recruiting CNAs & LPNs; utilizing Nurse Agency to supplement CNAs & LPNs; recruiting Nursing Aides for classes and training with intent to hire when qualified; and staffing meetings conducted in attempts to maintain State Mandated ratios for LPNs. 4. The DON and/or designee will randomly audit the staffing schedules to ensure the facility is staffed appropriately to reach the mandated State PPD. The results of the audits will be submitted to the QA Committee to determine if additional action is necessary.	Completion Date: **01/23/2025** Status: **APPROVED** Date: **12/26/2024**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640	Continued from page 6 Based on a review of nursing time schedules, it was determined that the facility failed to provide a minimum of 3.2 hours of direct care for each resident for eight of 21 days reviewed. Findings include: Review of nursing schedules for 21 days from September 1 through 7, October 25 through 31, and December 3 through 9, 2024, revealed the following total nursing care hours below minimum requirements: September 1, 2024: 3.16 care hours per resident. September 7, 2024: 2.63 care hours per resident. October 26, 2024: 2.97 care hours per resident. October 27, 2024: 3.16 care hours per resident. December 6, 2024: 3.19 care hours per resident. December 7, 2024: 2,86 care hours per resident. December 8, 2024: 3.15 care hours per resident. December 9, 2024: 3.10 care hours per resident.	P 5640		

Certified End Page

WEST READING SKILLED NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 902202

SURVEY EXIT DATE: 12/10/2024

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY