

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Rest Haven-York		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 South George Street York, PA 17403	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>34631</p> <p>Based on review of facility investigation, clinical record review, and staff interviews it was determined that the facility displayed past noncompliance, in that they had failed to ensure residents receive treatment and care in accordance with professional standards of practice and physician orders for one of seven residents reviewed (Resident 6).</p> <p>Findings Include:</p> <p>Review of Resident 6's clinical record revealed diagnoses that included Diabetes Mellitus Type II (a problem in the way the body regulates and uses sugar as a fuel) and vascular dementia (Brain damage caused by multiple strokes)</p> <p>Review of Resident 6's physician orders revealed an order that read Ozempic (semaglutide) pen injector; 0.25 mg or 0.5 mg .subcutaneous once a day on Friday.</p> <p>Review of Resident 6's Medication Administration Record (MAR), during the month of March 2024, revealed staff did not administer the medication on March 12, 2024, March 22, 2024 and March 29, 2024.</p> <p>The MAR revealed documentation of the reason the medication was not administered as Drug/Item unavailable.</p> <p>Review of Resident 6's MAR, during the month of April 2024, revealed staff did not administer the medication on April 5, 2024, with the reason documented as Drug/Item unavailable.</p> <p>An interview with the Nursing Home Administrator, on May 6, 2024, revealed the facility administrator had not been immediately informed of the medication being unavailable, however, once notified, management initiated an investigation, and a plan to address the missing medication.</p> <p>After the administrator was made aware of the missing medication, the medication was re-ordered and the resident was administered the medication. Review of the April and May MAR revealed that Resident 6 was administered the medication per physician order.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>After the identification of the missing medication, the facility initiated a plan of correction. Review of the facility's corrective action information revealed all weight loss, injectable medication pens, will be kept in the Supervisor's office. The Supervisor will be notified and the Supervisor and Licensed Practical Nurse (LPN) will administer the medication together. The Supervisor will keep a log of dates the medication was administered and the Supervisor will initial the medication was administered and document the LPN administered the medication. The facility educated staff and performed audits to ensure compliance.</p> <p>Prior to the abbreviated survey the facility failed to ensure Resident 6's medication was administered on four occasions, and inform facility administration and/or management of the medication not being available in order to administer to the resident. The facility immediately began an investigation when made aware, investigated the incident thoroughly, and initiated interventions in an effort to prevent a future incident.</p> <p>During the abbreviated survey audits, staff education, and initiated procedures regarding the process of administering injectable medications were observed and reviewed. Staff interviews revealed that staff were educated, and knowledgeable regarding the implemented procedures.</p> <p>28 Pa. Code 211.12 (d) (1) (2) (5) Nursing services</p>		