STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395058	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rest Haven-York	1050 South George Street York, PA 17403

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to maintain an effective infection control program related to labeling and storage of medical supplies for one of two residents reviewed with gastrostomy tubes (Resident 14). The facility also failed to provide a safe, sanitary, and comfortable environment to prevent the development and transmission of communicable diseases and infections during two of two meal observations in the Royal Garden Cafe. Findings include: Review of facility policy, titled Care of Enteral Feeding Tube-Position, Cleansing, Observation, Notification, Storage, last reviewed December 16, 2025, line 9 stated, All feeding tube syringes should be stored in a clean area. Reusable supplies should be labeled with the resident's name and date; cleansed with hot water after use; and disposed of after 24 hours. Review of Resident 14's clinical record revealed diagnoses that included dysphagia (difficulty swallowing) and gastrostomy (a surgical opening created through the abdominal wall into the stomach to insert a feeding tube for long-term nutrition, hydration, or medication delivery when oral intake is insufficient or unsafe). Review of Resident 14's current physician orders revealed most medications are administered via the gastrostomy tube. The gastrostomy tube was ordered to be flushed with 60 cc (metric measure 60 cc equals 2 ounces) of water every shift. Orders also said to flush the gastrostomy tube with 30 cc water before and after each med, also flush in between meds given separately. Observation of Resident 14's room on February 2, 2026, at approximately 11:00 AM, revealed the 60 cc piston syringe utilized for flushing the Resident's gastrostomy tube each shift laying on the bedside stand, uncovered and unlabeled; a graduate (measuring containing) was uncovered and unlabeled; and a gallon jug of water 2/3's full was not dated when placed into use. The bedside table was cluttered with many other personal items that included a comb, papers, and Kleenex box. During an interview with Employee 9 (Licensed Practical Nurse) on February 2, 2026, at 11:15 AM, Employee 9 was asked if the piston syringe and graduate should be protected and labeled, and if the gallon of water should be dated when placed into use. Employee 9 replied yes. Employee 9 then picked up the piston syringe and wrote 2/2/2026, on the syringe and placed it in the graduate container. Employee 9 stated he was unsure when the gallon of water was opened and left it sitting there for continued use. Employee 9 added, the syringe is replaced each day. On February 3, 2026, at 8:45 AM, the same 60 cc piston syringe dated 2/2/2026 was laying in the graduate container. The graduate container and water were not labeled with the Resident's name or date. During an interview with the Nursing Home Administrator (NHA) on February 4, 2026, at 10:50 AM, the NHA confirmed the piston syringe, graduate, and water container should be labeled with the Resident's name and dated when placed into use, and the syringe and graduate should be protected from contamination and should be replaced daily. Observation on February 4, 2026, at 12:00 PM, revealed Resident 60 was seated at a table being assisted by a staff member to eat her lunch. At the same table, staff assembled resident meal trays for service. The trays contained a napkin, uncovered silverware, beverages, and a meal ticket. Observation on February 4, 2026, at 12:05 PM, with Employee 5 (Food Service Director), revealed Resident 60 continued to be assisted with her meal at the table where staff assembled meal trays. At that time, Employee 5 revealed residents shouldn't be seated at the table where meal trays were being assembled. Interview with the NHA and Director of Nursing on (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	February 5, 2026, at 10:30 AM, it was revealed to avoid infection control concerns residents shouldn't be seated at the table where meal trays were being assembled. 28 Pa code 211.6(f) - Dietary Services28 Pa. Code 211.12 (d)(5) Nursing services

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on facility policy review, clinical record review, observations, and staff interview, it was determined that the facility failed to ensure a resident has the right to a dignified existence, including in an environment that promotes maintenance or enhancement of his or her quality of life, for one of 29 residents reviewed (Resident 7).Findings include:Review of facility policy, titled Resident Rights last reviewed December 16, 2025, read, in part, The resident has the right to an environment that promotes maintenance or enhancement of quality-of-life including respect, dignity and privacy.Review of Resident 7's clinical record revealed diagnoses that included urinary tract infection (an infection that takes place throughout your urinary tract), flaccid neuropathic bladder (the inability of the bladder muscles to contract effectively, leading to urinary retention and overflow incontinence), and weakness. Observation of Resident 7 on February 2, 2026, from 1:57 PM to 2:05 PM, revealed she wheeled herself from the dining room back to her room, and her catheter bag was hanging down underneath her chair with urine exposed. Observation of Resident 7 on February 4, 2026, at 11:36 AM, revealed she was sitting at a table in the dining room, and her catheter bag was facing outward underneath her chair with urine exposed. During an interview with the Director of Nursing on February 5, 2026, at 10:33 AM, she revealed she would expect residents to have the right to a dignified existence.28 Pa. Code 201.29(a) Resident rights

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, policy review, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure that the interdisciplinary team determined a resident was safe to self-administer medications for one of the 29 residents reviewed (Resident 10).Findings Include: Review of the facility's policy, titled Medication- Self Administration-Assessment, Review, Care Planning, Documentation, revised April 2022, read, the purpose of the policy is To provide a uniform process through which residents are assessed and reviewed to self-administer medication and care-planning, and documentation is completed. Review of Resident 10's clinical record revealed diagnoses that included Diabetes Mellitus Type II (a chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar) and Congestive Heart Failure (a chronic, progressive condition where the heart muscle is too weak or stiff to pump blood efficiently, causing fluid to back up into the lungs, liver, and extremities). An observation in Resident 10's room on February 2, 2026, at 10:31 AM, revealed a medication cup with multiple medications placed on the bedside table. An immediate interview with Resident 10 revealed that the Licensed Practical Nurse (Employee 10) leaves the medications there for him to take at his leisure and with his drink of choice. An interview with Employee 10 at 10:42 AM, revealed Resident 10 has not been assessed to self-administer his medications. An interview with the Nursing Home Administrator on February 4, 2026, at 10:44 AM, confirmed Employee 10 should not have left the medications at Resident 10's bedside, and confirmed Resident 10 has not been assessed by the facility to self-administer his medications. 28. Pa. Code 211. 12 (d) (1) (2) (5) Nursing services

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on facility policy, staff interviews, and clinical record reviews, it was determined that the facility failed to provide an explanation of the risks and benefits of psychotropic medications use and obtain consent prior to administering psychotropic medications for two of three residents reviewed for psychotropic medication use (Residents 15 and 45). Findings included: Review of Facility policy, titled Medications-Psychotropic Drugs - evaluating, monitoring and documenting, revised June 6, 2019, read, in part, if an anti-psychotic is ordered the resident and/or their responsible party will be educated on the risks versus benefits of taking the medication. Review of Resident 15s' clinical record revealed diagnoses that included delusional disorders (a mental health condition characterized by the presence of delusions- false, fixed beliefs about situations that could occur in real life), vascular dementia (a decline in thinking, memory, and behavior caused by conditions that damage brain blood vessels, restricting oxygen), depression (severe feelings of sadness, worthlessness, or hopelessness), and anxiety (feeling of fear, dread, and apprehension about perceived threats or impending misfortune). Resident 15's physician orders included: Haldol (antipsychotic used to treat behavioral issues or agitation, to manage hallucinations and delusions) 1 milligram (mg) once a day, started January 3, 2026; Haldol 0.5 mg twice a day, started January 3, 2026; and Trazadone (antidepressant approved to treat depressive disorder) 25 mg three times a day, started January 20, 2026. Review of psychology consult dated January 24, 2026, documented Haldol .25 mg was started on November 3, 2025, due to failed Geodon (antipsychotic medication) gradual dose reduction. Review of progress note dated November 3, 2025, read, in part, review antipsychotic risk versus benefit with Responsible Party and agrees with the medication. The name of the medication was not documented. Review of progress note dated November 4, 2025, read, in part, Resident admitted with orders for decrease Geodon and start Haldol. Letter sent to Responsible Party with a copy of the risk versus benefit of antipsychotic medications. Review of progress not dated January 20, 2026, read, in part, Trazodone 25 mg three times a day for continued signs of distress. Left message for Responsible Party. Interview with the Director of Nursing on February 5, 2026, at 10:30 AM, it was revealed that the facility should obtain consent and discuss the risks and benefits for use of an anti-psychotropic medication with the resident or resident representative prior to administration of the medication. Review of Resident 45's clinical record revealed diagnoses that included delusional disorder (defined by one or more persistent, fixed, false beliefs [often non-bizarre, such as being followed or poisoned] lasting at least one month) and dementia (a general term for severe mental function loss). Review of Resident 45's physician orders revealed an order for Risperidone (antipsychotic medication) 1 mg, given by mouth, three times daily, starting on August 26, 2025. Review of Resident 45's Care plan revealed a problem of: I have behavioral problems due to vascular dementia with psychotic features; Due to my behaviors I may require antipsychotic medication, with a start date of May 4, 2024. Review of Resident 45's medical record failed to reveal any documented education of the risks and benefits of or consent for Risperidone by Resident 45 or their Representative. Interview with the Nursing Home Administrator on February 3, 2026, at 11:45 AM, revealed that they could not provide any type of documented consent for Resident 45's Risperidone use. 28 Pa. Code:211.10(a) Resident care policies.28 Pa. Code:211.12(d)(1)(5) Nursing services.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on clinical record review, observation, and staff interviews, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for two of 29 residents reviewed (Residents 45 and 92). Findings Include: Review of Resident 45's clinical record revealed diagnoses that included chronic kidney disease (the long-term, irreversible loss of kidney function) and dementia (a general term for severe mental function loss). Review of Resident 45's Quarterly MDS (Minimum Data Set is part of federally mandated process for clinical assessment of all Medicare and Medicaid certified nursing homes) dated November 11, 2025, indicated in Section I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS) that Resident 45 had a UTI in the previous 30 days. Review of Resident 45's clinical record failed to reveal any evidence that Resident 45 had a UTI in the 30 days prior to November 11, 2025. Interview with the Nursing Home Administrator (NHA) on February 5, 2026, at 11:45 AM, revealed that Section 2300 was marked in error and a correction was being completed.Review of Resident 92's clinical record revealed diagnoses that included seborrheic dermatitis (a chronic inflammatory skin condition that causes flaky, white-op-yellowish scales, redness and greasy rash) and squamous cell cancer (cancer in outer layer of skin as well as the lining of hollow organs, respiratory tract and digestive tract) of scalp. Observation of Resident 92 on February 2, 2026, at 11:30 AM, revealed there was a large, scabbed area which covered the entire top of her head. Review of Resident 92's Quarterly MDSs dated November 11, 2025; August 12, 2025; and May 15, 2025, failed to document a diagnosis of cancer in Section I. Interview with Employee 8 (Registered Nurse Assessment Coordinator), Director of Nursing, and the NHA on February 5, 2026, at 10:30 AM, revealed the aforementioned MDSs should've documented cancer as an active diagnosis. 28 Pa Code 211.12 (d)(3)(5) Nursing Services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on policy review, observations, and staff interviews, it was determined that the facility failed to provide respiratory services for two of two residents reviewed for respiratory care (Residents 141 and 144). Findings include:Review of facility provided policy, titled Oxygen Therapy- Assessment, Notification, Application, Documentation, last revised April 25, 2018, failed to reveal an expectation for physician's orders for supplemental oxygen. Review of Resident 141's clinical record revealed diagnoses that included chronic obstructive pulmonary disease (COPD - a progressive, incurable, but treatable lung disease) and acute kidney failure (a sudden and often temporary loss of kidney function).Observation of Resident 141 on February 5, 2026, at 10:24 AM, revealed Resident 141 sitting in their wheelchair at bedside. Resident 141 was wearing a nasal canula (oxygen delivery device) and receiving supplemental oxygen at 2 liters per minute.Review of Resident 141's care plan revealed a care plan of: I (Resident 141) have COPD, with a start date of January 20, 2026. Further review of the care plan failed to reveal the amount of supplemental oxygen to be delivered to Resident 141 or the oxygen delivery method.Review of current physician orders for Resident 141 revealed an order for, Routine oxygen use- check oxygen saturation every shift- document hours, liters, and source every shift, with a start date of January 21, 2026. Further review failed to reveal any physician's order for the amount of oxygen to be delivered to Resident 141 or the oxygen delivery method to be used.Review of Resident 144's clinical record revealed diagnoses that included COPD and bronchiectasis (a lung condition that causes cough, sputum production, and recurrent respiratory infections).Observation of Resident 144 on February 2, 2026, at 11:22 AM, revealed Resident 144 sitting in their wheelchair at bedside. Resident 141 was wearing a nasal canula and receiving supplemental oxygen at 3 liters per minute.Review of Resident 144's care plan revealed a care plan of: I (Resident 144) have COPD, with a start date of January 29, 2026. Further review of the care plan failed to reveal the amount of supplemental oxygen to be delivered to Resident 144 or the oxygen delivery method.Review of current physician orders for Resident 144 revealed an order for, Routine oxygen use- check oxygen saturation every shift- document hours, liters, and source every shift with a start date of January 12, 2026. Further review failed to reveal any physician's order for the amount of oxygen to be delivered to Resident 144 or the oxygen delivery method to be used.Interview with the Director of Nursing on February 6, 2026, at 10:15 AM, revealed that she is aware of the orders.28 Pa. Code 211.12(d)(1) Nursing services. 28 Pa. Code 211.12(d)(3) Nursing services. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on facility policy, clinical record review, and resident and staff interviews, it was determined that the facility failed to maintain complete and accurate records related to dialysis communication for one of two residents reviewed that received dialysis services (Resident 12). Findings Include: Review of facility policy, titled Dialysis Care of Resident- transport, communication, observation, documentation, last revised January 2, 2017, read, in part, the facility is to communicate with dialysis facility. Prior to dialysis, pre-dialysis observation will be completed and sent with or faxed to dialysis center. Upon return from dialysis, a post-dialysis observation will be completed, and physician and dialysis center will be notified as needed. Review of Resident 12's clinical record revealed diagnoses that included end stage renal disease (kidneys don't function properly) and dependence on renal dialysis. Review of Resident 12's February 2026 physician orders included: complete pre-dialysis observation once a day on Monday/Wednesday/Friday 2 PM - 4 PM, start October 12, 2025; and complete post-dialysis observation once a day on Monday/Wednesday/Friday 2 PM - 4 PM, start October 3, 2025. No documented physician orders for dialysis. Review of Resident 12's care plan documented a focus area for Resident has hemodialysis due to renal failure, last edited January 15, 2026. Interventions included dialysis treatments Monday/Wednesday/Friday, last edited September 29, 2025; staff to monitor and document vital signs - blood pressure left or right arm, respirations, pulse, pulse oximetry, temperature, and weight, last edited September 29, 2025; dialysis treatments per physician order, last edited September 29, 2025. Review of Resident 12's electronic medical record failed to document complete pre- or post-dialysis assessments on December 5th, 17th, 22nd, 2025; and January 9th, 14th, 23rd, 26th, and 28th, 2026. The facility assessments that were completed didn't include weight monitoring. Interview with Employee 6 (Licensed Practical Nurse [LPN]) on February 2, 2026, at 10:30 AM, revealed the facility doesn't maintain documentation of communication with the dialysis center. The facility completes an assessment pre- and post-dialysis to monitor blood pressure, but not weight. Interview with the Director of Nursing on February 5, 2026, at 10:40 AM, it was revealed facility pre- and post-dialysis assessments should be completed. It was also revealed that communication between the dialysis center and the facility should be available. 28 Pa Code 211.5(f) Clinical records28 Pa. Code 211.12 (d)(1)(3)(5) Nursing service

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of the ice machine equipment manual, observations, and staff interviews, it was determined that the facility failed to store and serve food/beverages in accordance with professional standards for food safety for one of three pantry refrigerators and one of three ice machines. Findings include: Review of the ice machine manual, section 4- maintenance, read, in part, clean and sanitize the ice machine a minimum of every six months. If the machine requires more frequent cleaning and sanitizing, consult a qualified service company to test the water quality and recommend appropriate water treatment. An extremely dirty ice machine must be taken apart for cleaning and sanitizing. Observation with Employee 1 (Registered Dietitian) on February 2, 2026, at 9:40 AM, of inside the Flowers unit nourishment refrigerator revealed dried yellow and red liquids were noted on the bottom shelf. At that time, Employee 1 revealed the refrigerator needs to be cleaned. Observation with Employee 2 (Licensed Practical Nurse [LPN]) on February 3, 2026, at 9:49 AM, in the ice machine on Lilly Lane revealed pink and black substances on the baffle/deflector that was able to be wiped away with a dry paper towel. The inside top panel of the ice machine, the drip tray, and the bottom rim of the cover in front of the evaporator grid contained a black substance that was able to be wiped with a dry paper towel. At that time, Employee 1 stated that maintenance was in the process of cleaning the machine.Interview with Employee 3 (Maintenance) on February 3, 2026, at 9:55 AM, revealed that someone touched the ice, and he was in the process of emptying the machine and cleaning the inside of the machine.At that time, the surveyor pointed out the concern with the pink and black substance on the drip ledge and the black substance on the inside top panel of the ice machine, the drip tray, and the bottom rim of the cover in front of the evaporator grid. Employee 3 then stated, he uses a chemical to clean the machine; he was not sure what the name of the chemical was.Observation at 10:05 AM, revealed Employee 4 (Director of Operations) was providing instructions to Employee 3 on how to clean the ice machine. At that time, interview with Employee 4 revealed the ice machines are on a 6-month cleaning schedule.Review of Lily Lane ice machine inspection check sheet documented the ice machine was inspection February 2, 2026; and September 2, 2025.Interview with the Nursing Home Administrator on February 5, 2026, at 10:30 AM, revealed the refrigerator and ice machine should be clean. 28 Pa code 211.6(f) - Dietary Services