STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395290	A. Building B. Wing	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Acres Rehabilitation and Nursing Center	118 Pleasant Acres Rd,rd7 York, PA 17402

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46253 Based on facility policy review, clinical record reviews, and staff interviews, it was determined that the facility failed to timely notify a resident's physician of a change in condition for two of four residents reviewed (Residents 1 and 4); and failed to notify a resident's responsible party of a change in condition and/or treatment changes for four of four residents reviewed (Residents 1, 2, 3, and 4). Findings include: Review of facility policy, titled Change in Condition, with a last revised date of June 28, 2023, revealed the following: The Clinical Nurse will recognize and appropriately intervene in the event of a change in resident condition. The Facility will notify the resident, attending physician and resident representative of changes in the resident' s condition and/or status; 1. If the CNA [Certified Nurse Assistant] identifies a change in resident's condition he/she will immediately notify the nurse of the situation. 2. The nurse will communicate to the nurse manager/supervisor any change in resident condition as it occurs. This will also be communicated in the 24 hour/and or shift report as well; 3. The resident, attending physician and resident representative, if applicable, will be notified promptly of a significant change in condition, accident/incident, change in treatment, and/or transfer/discharge; and 4. If a significant change in condition occurs, a physical and or mental assessment will be completed by the Registered Nurse and documented in the medical record. Review of facility policy, titled Physician Notification, with a last review date of March 2023, revealed, in part: Policy: To foster the Philosophy of the facility, in compliance with Federal and State Regulations, to ensure physician response to phone calls made by the facility in regard to status changes of the residents is done in a timely manner; 1) The following circumstances require physician notification but the list is not all inclusive: a. There is a change in the mental, physical or functional status of the resident; 2) Timeframe for notification a. Notify the physician by phone or in person with onset of any significant change in a timely manner; and 4) In the event that the physician and/or back-up physician does not return a call, the Unit Manager/Supervisor will be notified and he/she will make another attempt to contact the physician. The DON [Director of Nursing]/designee will be notified of the situation; and 6) The Medical Director is ultimately responsible for all residents, and will be notified in the event that another attending physician does not respond. The Medical Director will provide any orders pertinent to the delivery of care of the residents. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/01/2024
NAME OF PROVIDER OR SUPPLIER Pleasant Acres Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 118 Pleasant Acres Rd,rd7 York, PA 17402	

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 1's clinical record revealed diagnoses that included dementia with agitation (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning) and type II diabetes mellitus (disease that occurs when your blood glucose, also called blood sugar, is too high, but does not require the use of insulin). Review of Resident 1's clinical progress notes revealed a nutrition dietary note dated December 1, 2023, at 4:10 PM, which indicated that Resident 1 had experienced 5% weight loss in one month and a 10% weight loss in six months, which was not planned. The note further indicated that the dietician made recommendations to add ice cream to dinner tray, add whole milk to breakfast and lunch tray, and to add super cereal to breakfast tray. Progress notes failed to reveal that Resident 1's physician or responsible party were made aware of the weight loss and the new recommendations from December 1, 2023. Further review of Resident 1's progress notes for December 1, 2023, revealed that they were seen by their physician at 10:20 AM, but the progress note failed to include any notation or assessment of Resident 1's weight loss. Review of Resident 1's clinical progress notes revealed a nutrition dietary note dated January 8, 2024, at 4:02 PM, that indicated they had a significant weight loss noted for two months, and that the weight loss was undesired and unplanned. The note further indicated that the dietician made a recommendation to provide a magic cup daily. Further review of Resident 1's progress notes failed to reveal any documentation that their responsible party was made aware of the ongoing weight loss or the new dietary recommendation from January 8, 2024. Review of Resident 1's physician visit progress note dated January 29, 2024, at 3:05 PM, revealed that Resident 1's blood sugars were elevated during the day and up to 300 by evening, and that the physician was increasing their Lantus (an injectable medication used to treat diabetes) dose. Further review of Resident 1's progress notes failed to reveal any documentation that their responsible party was made aware of the ongoing elevated blood sugars or the medication change order from January 29, 2024. Review of Resident 1's progress notes revealed a note dated February 16, 2024, at 5:22 PM, which indicated that their physician was made aware of an exposure to Influenza A, and that a new order was obtained to administer Tamiflu (an antiviral oral medication used to treat the flu). Further review of Resident 1's progress notes failed to reveal any documentation that their responsible party was made aware of Resident 1's exposure to the flu or their new medication order from February 16, 2024. Review of Resident 2's clinical record revealed diagnoses that included dementia and depression. Review of Resident 2's progress notes revealed a note dated February 16, 2024, at 5:44 PM, which indicated that their physician was made aware of an exposure to Influenza A, and that a new order was obtained to administer Tamiflu (an antiviral oral medication used to treat the flu). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident 2's progress notes failed to reveal any documentation that their responsible party was made aware of Resident 2's exposure to the flu or their new medication order from February 16, 2024. Review of Resident 3's clinical record revealed diagnoses that included dementia and unspecified intellectual disabilities. Review of Resident 3's progress notes revealed a nurse's note dated November 28, 2023, at 2:15 PM, which indicated that they had a moist, non-productive cough, and wheezing. The note indicated that the physician was present on the unit, assessed Resident 3, and that new orders were placed. Further review of Resident 3's progress notes failed to reveal any documentation that their responsible party was made aware of Resident 3's change in condition and new treatment orders from November 28, 2023. Review of Resident 3's progress notes revealed a nurse's note dated December 19, 2023, at 2:43 PM, that indicated Resident 3's right lower leg was noted to be red, warm to the touch, with swelling noted. The note further indicated that Resident 3 was started on an antibiotic by the physician. Further review of Resident 3's progress notes failed to reveal any documentation that their responsible party was made aware of Resident 3's change in condition and new treatment orders from December 19, 2023. Review of Resident 3's progress notes revealed a nurse's note dated December 21, 2023, at 5:53 PM, which indicated that an ordered x-ray could not be completed secondary to Resident 3's inability to comply with instructions, that their physician was notified, and that an order was given to discontinue the x-ray order. Further review of Resident 3's progress notes failed to reveal any documentation that their responsible party was made aware of Resident 3's discontinued order from December 21, 2023. Review of Resident 3's progress notes revealed a note dated January 23, 2024, at 10:26 AM, which indicated that Resident 3 was noted to be coughing frequently, that their physician assessed them, and that several new medications were ordered. Further review of Resident 3's progress notes failed to reveal any documentation that their responsible party was made aware of Resident 3's change in condition and new treatment orders from January 23, 2024. Review of Resident 3's progress notes revealed a note dated February 16, 2024, at 4:58 PM, which indicated that their physician was made aware of an exposure to Influenza A, and that a new order was obtained to administer Tamiflu (an antiviral oral medication used to treat the flu). Further review of Resident 3's progress notes failed to reveal any documentation that their responsible party was made aware of Resident 3's exposure to the flu or their new medication order from February 16, 2024. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 3's progress notes revealed a note dated February 20, 2024, at 10:23 PM, which indicated that Resident 3 was struggling to swallow their food, was struggling to swallow thin liquids with coughing noted, that their physician was made aware, and that a consult was sent to speech therapy for an evaluation. Further review of Resident 3's progress notes failed to reveal any documentation that their responsible party was made aware of Resident 3's change in condition and new order from February 20, 2024. Review of Resident 4's clinical record revealed diagnoses that included dementia and depression. Review of Resident 4's progress notes revealed a note by Employee 1 (LPN - Licensed Practical Nurse) dated February 20, 2024, at 6:08 AM, which indicated that Resident 4's bilateral feet were purple and cold to touch, that they had movement to both feet and all toes, that positive sensation was noted when pressure was applied to the nail beds, and that Employee 1 was unable to check pulses in Resident 4's feet because they were restless. The note further indicated that Resident 4 was refusing to wear socks or keep feet covered for warmth to any extent, and that this information was placed on report and the doctors' board. Documentation failed to reveal that Resident 4's condition was reported to a Registered Nurse (RN), that a RN assessed Resident 4, or that Resident 4's responsible party was notified of their change in condition. Review of Resident 4's progress notes revealed a note by Employee 2 (LPN) dated February 20, 2024, at 2:45 PM, which indicated that Resident 4's bilateral feet were purple and cold to the touch, they had a low oxygen saturation rate, that oxygen was applied but Resident 4 kept removing it, their oxygen saturation improved without the oxygen, and that the unit manager was notified. Documentation failed to reveal that Resident 4 was assessed by a RN, that their physician had responded to the information, that any follow-up with Resident 4's physician regarding their ongoing change in condition was completed, or that their responsible party was notified of their change in condition on February 20, 2024. Review of Resident 4's progress notes revealed that the next note entered was by Employee 3 (RN) dated February 21, 2024, at 5:24 AM,which indicated Resident 4 was restless and weak all through the night, that they appeared to be awake most of the time during the shift, and that their vital signs were taken with no identified concerns. Documentation failed to reveal that Resident 4's had been seen by their physician, that any follow-up with Resident 4's physician regarding their ongoing change in condition was completed, or that their responsible party was notified of their change in condition. Review of Resident 4's progress notes revealed that the next note entered was by Employee 4 (RN) dated February 21, 2024, at 11:46 AM, which indicated that Resident 4's doctor was notified and will be up to assess. Documentation failed to reveal that Resident 4's responsible party was notified of their ongoing change in condition. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 4's progress revealed that the next note entered was another note by Employee 4 (RN) dated February 21, 2024, at 12:07 PM, which indicated Resident 4 was assessed that morning and that their bilateral feet were ice cold, pedal pulses (pulses located in the top of the foot) were negative, and skin color blue. Review of Resident 4's progress notes revealed a note by Employee 4 dated February 21, 2024, at 12:54 PM, which indicated that Resident 4's physician was in to assess Resident, gave an order to transfer them to the hospital, and that their responsible party was notified. Email communication received from the Director of Nursing (DON) on February 27, 2023, at 4:21 PM, revealed that most responsible party notifications are noted in the progress notes for new orders and change in conditions, and that sometimes a physician will contact the family and complete the notification then document it in their note. A follow-up email communication was sent to the Nursing Home Administrator (NHA) and DON on February 28, 2024, at 9:11 AM, which shared all the aforementioned notification concerns and request was made for any additional information that they had to provide. Email communication received from the DON on February 28, 2024, at 2:04 PM, indicated that she had spoken to Employee 4 who assessed Resident 4 on February 20, 2024, and she stated that she notified the physician that day as they were in the facility. She further indicated that there was no note placed in the electronic health record, but that she had a statement to this affect. Review of the staff statement provided by the DON on February 28, 2024, at 3:43 PM, revealed that on February 20, 2024, Employee 4 was notified at end of shift that res[ident] had a drop in 02 [oxygen] level and was placed on 2L [liters of oxygen] per nursing judgment. Res[ident] showed no s/s [signs and symptoms] of distress/SOB [shortness of breath] at the time. LPN [Employee 2] later came back and said res[ident] was not keeping the oxygen on and stated she would recheck 02 [oxygen] in a little before she left. She then came back and stated that the recheck was 96-97% RA [room air] and res[ident] was resting comfortably in bed at that time. Writer was told that provider was aware of res[ident] and awaiting orders. The statement further indicated that on February 21, 2024, Employee 4 came up to unit, looked at Dr's (doctor's) boards, and started looking at 24 report to see what needed f/u [follow-up]. Writer saw there wasn't any f/u [follow-up] noted on res[ident], went to assess and called the provider to come to unit to assess. Provider stated he would be up shortly to assess. He later came to unit and notified writer that he spoken to res[ident]daughter and wanted to send res[ident] out for eval [evaluation] and tx [treatment]. Email communication was sent to the NHA and DON on February 29, 2024, at 8:12 AM, requesting additional follow-up information as this statement did not confirm that Resident 4's condition was assessed by Employee 4 on February 20, 2024, when Employee 2 reported the continued change in Resident 4's condition. In addition, information was requested again in regards to no follow-up with Resident 4's physician or responsible party notification. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Email communication received from the DON on February 29, 2024, at 9:38 AM, indicated that Employee 4 confirmed with Employee 2 that Resident 4's physician was made aware and stated he would follow-up and assess the resident. The DON confirmed that when Employee 4 came in on dayshift on February 21, 2024, she noted she did not see any follow-up from Resident 4's physician, and that she then called Resident 4's physician again and he stated he would be up to assess the Resident. Email communication was sent to the NHA and DON on February 29, 2024, at 10:27 AM, requesting additional information regarding why RN assessments were not completed when LPN's were noting changes in Resident 4's condition, and why was there no follow-up with the physician prior to February 21, 2024, at 11:46 AM, when he had not responded to assess Resident 4 after he was notified on the morning of February 20, 2024, around 6:00 AM. Email communication received from DON on February 29, 2024, at 2:29 PM, indicated the following: the LPN put it on the physician board for them to review during rounds as the MD was in the facility when the change was first identified; that the LPN notified the RN at 1445 of the change in oxygen saturation however at that time the resident had stabilized and they were under the impression from the MD that he was going to assess the resident himself; and that the MD was notified and made aware of the change in condition on the 20th and resident did not have a further change prior to the MD assessing resident on the 21st. Review of Resident 4's meal intake task documentation revealed the following information: February 17, 2024, for breakfast and lunch the Resident consumed 26-50% and consumed 51-75% with supper; February 18, 2024, there was no documentation provided for breakfast or lunch; the resident consumed 51-75% of supper; February 19, 2024, for breakfast and lunch the resident consumed 0-25% and at supper consumed 26-50%; February 20, 2024, the resident consumed 0-25% of all 3 meals; and February 21, 2024, for breakfast and lunch the resident consumed 0-25%. Review of Resident 4's fluid intake with meals task documentation revealed the following: February 17, 2024: there was documentation of refusal at breakfast, consumed 240 cc (cubic centimeters) at lunch, and consumed 380 cc with supper; February 18, 2024: 160 cc consumed with supper; February 19, 2024: 120 cc consumed with breakfast, 0 cc consumed with lunch, and 240 cc consumed with supper; February 20, 2024: 120 cc consumed with breakfast, 0 cc consumed at lunch, and 100cc consumed with supper; and (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	February 21, 2024: 0 cc consumed with breakfast and lunch. Further review of Resident 4's clinical record failed to reveal any documentation that nurse aides had reported Resident 4's decline in meal and fluid intakes between February 17-21, 2024, that a RN assessed this decline in meal and fluid intakes, that the physician was notified of the decline in meal and fluid intakes, or that Resident 4's responsible party was made aware of the decline in meal and fluid intakes prior to February 21, 2024. Review of Resident 4's physician progress note dated February 21, 2024, revealed that Resident 4 had poor oral intake; was having a mental status change; that the resident was barely responsive and had extremely poor skin turgor (elasticity of the skin); that they had dehydration, progression of dementia; possible recurrent urinary tract infection; possible sepsis (potentially life-threatening condition that arises when the body's response to infection causes injury to it's own tissues and organs); was being sent to the hospital emergency room ; and that Resident 4's responsible party was notified. Review of Resident 4's hospital emergency room history and physical dated February 21, 2024, at 1:47 PM, revealed that the Resident had arrived at the hospital unresponsive, was in acute distress, was evaluated by the emergency room and noted to be septic with an elevated white blood cell count, elevated lactic acid (a chemical the body produces when your cells break down carbohydrates for energy), elevated heart rate, and low blood pressure. The note further indicated that the physician wanted to admit Resident 4 to the intensive care unit, but their family requested that only comfort care be provided. Further review of Resident 4's hospital record revealed that they ceased to breathe on February 21, 2024, at 11:15 PM. Follow-up email communication received from the NHA on March 1, 2024, at 2:28 PM, indicated that the facility had no additional information to share in regards to the aforementioned concerns with Resident 4's change in condition, physician notification, or responsible party notification. During a final interview with the NHA, Assistant NHA, and DON on March 1, 2024, at 3:15 PM, the NHA confirmed that resident's physicians should have been notified of all changes in condition, that an RN should assess residents when they have a noted change in condition, and that residents and/or their responsible parties should be notified when a resident experiences a change in condition. The DON indicated that Resident 4's change in condition was placed on the physician's board and that the physician indicated that he would go look at them. The facility did not provide any documentation to support this or that the facility was continuing to follow-up with Resident 4's physician secondary to their ongoing change in condition prior to February 21, 2024, at 11:46 AM. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46253 Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards for one of four residents reviewed (Resident 4). Findings Include: Review of facility policy, titled Change in Condition, with a last revised date of June 28, 2023, revealed the following, in part: The Clinical Nurse will recognize and appropriately intervene in the event of a change in resident condition. The Facility will notify the resident, attending physician and resident representative of changes in the resident's condition and/or status; 1. If the CNA [Certified Nurse Assistant] identifies a change in resident's condition he/she will immediately notify the nurse of the situation; 2. The nurse will communicate to the nurse manager/supervisor any change in resident condition as it occurs. This will also be communicated in the 24 hour/and or shift report as well; and 4. If a significant change in condition occurs, a physical and or mental assessment will be completed by the Registered Nurse and documented in the medical record. Review of Resident 4's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning) and depression. Review of Resident 4's progress notes revealed a note by Employee 1 (LPN - Licensed Practical Nurse) dated February 20, 2024, at 6:08 AM, which indicated that Resident 4's bilateral feet were purple and cold to touch, that the resident had movement to both feet and all toes, that positive sensation was noted when pressure was applied to the nail beds, and that Employee 1 was unable to check pulses in Resident 4's feet because they were restless. The note further indicated that Resident 4 was refusing to wear socks or keep feet covered for warmth to any extent, and that this information was placed on report and the doctors' board. Documentation failed to reveal that Resident 4's condition was reported to a Registered Nurse (RN) or that an RN assessed Resident 4. Review of Resident 4's progress notes revealed a note by Employee 2 (LPN) dated February 20, 2024, at 2:45 PM, which indicated that Resident 4's bilateral feet were purple and cold to the touch, the resident had a low oxygen saturation rate, that oxygen was applied but Resident 4 kept removing it, their oxygen saturation improved without the oxygen, and that the unit manager (Employee 4 [RN]) was notified. Documentation failed to reveal that Resident 4 was assessed by an RN or that any follow-up with Resident 4's physician regarding their ongoing change in condition was completed. Review of Resident 4's progress notes revealed that the next note entered was by Employee 3 (RN) dated February 21, 2024, at 5:24 AM, which indicated Resident 4 was restless and weak all through the night, that the resident appeared to be awake most of the time during the shift, and that their vital signs were taken with no identified concerns. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Documentation failed to reveal that any follow-up with Resident 4's physician regarding their ongoing change in condition was completed. Review of Resident 4's progress revealed another note by Employee 4 dated February 21, 2024, at 12:07 PM, which indicated Resident 4 was assessed that morning and that their bilateral feet were ice cold, pedal pulses (pulses located in the top of the foot) were negative, and skin color blue. Review of Resident 4's progress notes revealed a note by Employee 4 dated February 21, 2024, at 12:54 PM, which indicated that Resident 4's physician was in to assess resident and gave an order to transfer them to the hospital. An email communication was sent to the Nursing Home Administrator (NHA) and Director of Nursing (DON) on February 28, 2024, at 9:11 AM, which shared the aforementioned concerns and request was made for any additional information that they had to provide. Email communication received from the the DON on February 28, 2024, at 2:04 PM, indicated that she had spoken to Employee 4, who assessed Resident 4 on February 20, 2024, and she stated that she notified the physician that day as they were in the facility. She further indicated that there was no note placed in the electronic health record, but that she had a statement to this affect. Review of Employee 4's statement, provided by the DON on February 28, 2024, at 3:43 PM, revealed that on February 20, 2024, Employee 4 was notified at end of shift that res[ident] had a drop in 02 [oxygen] level and was placed on 2L [liters of oxygen] per nursing judgment. Res[ident] showed no s/s [signs and symptoms] of distress/SOB [shortness of breath] at the time. LPN [Employee 2] later came back and said res[ident] was not keeping the oxygen on and stated she would recheck 02 [oxygen] in a little before she left. She then came back and stated that the recheck was 96-97% RA [room air] and res[ident] was resting comfortably in bed at that time. Writer was told that provider was aware of res[ident] and awaiting orders. The statement further indicated that on February 21, 2024, Employee 4 came up to unit, looked at Dr's (doctor's) boards, and started looking at 24 hour report to see what needed f/u [follow-up]. Writer saw there wasn't any f/u [follow-up] noted on res[ident], went to assess and called the provider to come to unit to assess. Provider stated he would be up shortly to assess. He later came to unit and notified writer that he spoken to res[ident]daughter and wanted to send res[ident] out for eval [evaluation] and tx [treatment]. Writer placed all orders and started to get all paperwork together to send res out to hospital. Email communication was sent to NHA and DON on February 29, 2024, at 8:12 AM, requesting additional follow-up information as this statement did not confirm that Resident 4's condition was assessed by Employee 4 on February 20, 2024, when Employee 2 reported the continued change in Resident 4's condition. In addition, information was requested again in regards to no follow-up with Resident 4's physician regarding their ongoing change in condition. Email communication received from the DON on February 29, 2024, at 9:38 AM, indicated that Employee 4 confirmed with Employee 2 that Resident 4's physician was made aware, and he stated he would follow-up and assess the resident. The DON confirmed that when Employee 4 came in on dayshift on February 21, 2024, she noted she did not see any follow-up from Resident 4's physician, that she then called Resident 4's physician again, and that he stated he would be up to assess the Resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/01/2024
NAME OF PROVIDER OR SUPPLIER Pleasant Acres Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 118 Pleasant Acres Rd,rd7 York, PA 17402	

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Email communication was sent to the NHA and DON on February 29, 2024, at 10:27 AM, requesting additional information regarding why RN assessments were not completed when LPN's were noting changes in Resident 4's condition, and why was there no follow-up with the physician prior to February 21, 2024, at 11:46 AM, when he had not responded to assess Resident 4 after he was notified on the morning of February 20, 2024, around 6:00 AM. Email communication received from the DON on February 29, 2024, at 2:29 PM, indicated the following: the LPN put it on the physician board for them to review during rounds as the MD was in the facility when the change was first identified; that the LPN notified the RN at 1445 of the change in oxygen saturation, however at that time the resident had stabilized and they were under the impression from the MD that he was going to assess the resident himself; and that the MD was notified and made aware of the change in condition on the 20th and resident did not have a further change prior to the MD assessing resident on the 21st. Review of Resident 4's meal intake task documentation revealed the following information: February 17, 2024, for breakfast and lunch the resident consumed 26-50% and consumed 51-75% with supper; February 18, 2024, there was no documentation provided for breakfast or lunch; the resident consumed 51-75% of supper; February 19, 2024, for breakfast and lunch the resident consumed 0-25% and at supper consumed 26-50%; February 20, 2024, the resident consumed 0-25% of all 3 meals; and February 21, 2024, for breakfast and lunch the resident consumed 0-25%. Review of Resident 4's fluid intake with meals task documentation revealed the following: February 17, 2024: there was documentation of refusal at breakfast, consumed 240 cc (cubic centimeters) at lunch, and consumed 380 cc with supper; February 18, 2024: there was only documentation of 160 cc consumed with supper; February 19, 2024: 120 cc consumed with breakfast, 0 cc consumed with lunch, and 240 cc consumed with supper; February 20, 2024: 120 cc consumed with breakfast, 0 cc consumed at lunch, and 100 cc consumed with supper; and February 21, 2024: 0 cc consumed with breakfast and lunch. Further review of Resident 4's clinical record failed to reveal any documentation that nurse aides had reported Resident 4's decline in meal and fluid intakes between February 17-21, 2024, that an RN assessed this decline in meal and fluid intakes, or that the physician was notified of the decline in meal and fluid intakes prior to February 21, 2024. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 4's physician progress note dated February 21, 2024, revealed that Resident 4 had poor oral intake; was having a mental status change; that they were barely responsive; had extremely poor skin turgor; that they had dehydration, progression of dementia; possible recurrent urinary tract infection; possible sepsis; was being sent to the hospital emergency room ; and that Resident 4's responsible party was notified. Review of Resident 4's hospital emergency room history and physical dated February 21, 2024, at 1:47 PM, revealed that the Resident had arrived at the hospital unresponsive, was in acute distress, was evaluated by the emergency room and noted to be septic with an elevated white blood cell count, elevated lactic acid (a chemical the body produces when your cells break down carbohydrates for energy), elevated heart rate, and low blood pressure. The note further indicated that the physician wanted to admit Resident 4 to the intensive care unit, but their family requested that only comfort care be provided. Further review of Resident 4's hospital record revealed that they ceased to breathe on February 21, 2024, at 11:15 PM. Follow-up email communication received from the NHA on March 1, 2024, at 2:28 PM, indicated that the facility had no additional information to share in regards to the aforementioned concerns with Resident 4's change in condition, RN assessments, or physician notification of noted changes in condition. During a final interview with the NHA, Assistant NHA, and DON on March 1, 2024, at 3:15 PM, the NHA confirmed that changes in a resident's status should be reported to a Registered Nurse, who would assess this change and complete necessary follow-up with the resident's physician. The DON indicated that Resident 4's change in condition was placed on the physician's board and that the physician indicated that he would go look at them. The facility did not provide any documentation to support this or that facility staff were continuing to follow-up with Resident 4's physician secondary to their ongoing change in condition prior to February 21, 2024, at 11:46 AM. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46253 Based on facility policy review, clinical record review, facility incident report review, and staff interviews, it was determined that the facility failed to ensure that residents received adequate assistance to prevent accidents for one of three residents reviewed (Resident 3); and failed to ensure that a thorough investigation was conducted following falls for two of three residents reviewed (Residents 3 and 4). Findings include: Review of facility policy, titled Incident Reporting and Investigation of Accident Hazards, Supervision, Assistive Devices, with a last revised date of January 17, 2023, revealed the following, in part: The Facility will thoroughly investigate any adverse occurrence which is not consistent with the routine operation of the Facility or care of a resident(s); 3. Complete the incident report: a. Collect information that is related to the facts and circumstances of the incident being investigated; e. Interview all potential witnesses; obtain information about what was actually observed; Data Analysis: a. Summarize analysis of facts gathered that: Establish reasonable cause for the incident; or Establish need for further investigation, before a reasonable cause of the incident can be established; d. Conclude why the incident occurred, if possible; e. Document the following results/analysis on the accident/incident 'note section in PCC' or final Disposition/investigation report. How the incident occurred; Why the incident occurred; and Root cause analysis, if able to determine. Review of Resident 3's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), muscle weakness, lack of coordination, and unspecified intellectual disabilities. Review of Resident 3 clinical record revealed a progress note dated December 20, 2023, at 7:45 PM, which stated that the resident was witnessed falling out of a chair in the TV room while sleeping and hitting their face on the floor. The note also indicated that Resident 3 had a bloody nose with bruising and deformity. Review of facility incident report dated December 20, 2023, at 7:45 PM, confirmed that Resident 3 was noted to have been sleeping in a chair. The following sections of the investigation portion of the Resident 3's facility incident report were noted to be blank: mental status; predisposing environmental factors, predisposing physiological factors; and predisposing situation factors. Email communication received from the Director of Nursing (DON) on February 29, 2024, at 2:51 PM, indicated for Resident 3's fall if none of the predisposing factors were applicable then it would show up blank. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of witness statement from Employee 5 (nurse aide) indicated that she was sitting and monitoring the TV room and continuously saw [Resident 3] leaning over in her chair sleeping. I woke her up twice and had her sit up, but kept falling asleep. I was tending to another resident and looked over to check on [Resident 3] when I saw her leaning further forward and by the time I was rushing to her she was already falling onto the floor. Her face hit directly onto the floor and her nose started bleeding and immediately bruised. During an interview with the DON on February 26, 2024, at 1:45 PM, she indicated that they have an assigned staff member to monitor the TV room for safety purposes. She indicated that the aide may have been waiting for someone to come and assist the resident to bed since she could not leave the area. She confirmed that there were no other statements obtained to determine when care was last provided for Resident 3, or if the nurse aide had sought any help to assist Resident 3 back to bed prior to the fall when they were noted to be sleeping in the chair. She indicated that the interdisciplinary team had reviewed the fall and ruled out abuse and neglect. She further indicated that the new care plan intervention for Resident 3 post-fall was to offer the resident to lay down when sleeping in resident areas. Review of available documentation failed to reveal any evidence that Employee 5 asked for assistance with Resident 3, or took any additional steps to ensure Resident 3's safety. Review of Resident 4's clinical record revealed diagnoses that included dementia, muscle weakness, lack of coordination, and depression. Review of Resident 4's clinical record revealed a progress note dated February 28, 2024, at 12:45 PM, that indicated that Resident 4 was found on the floor to the left of their bed, with their feet facing the head of the bed and their head facing the foot of the bed. Resident 4 was noted to be confused per their baseline and could not state what had occurred. The progress note further indicated that Resident 4 had no injuries when assessed. Review of facility incident report dated February 18, 2024, at 12:45 PM, included the information as noted in the above progress notes, but also stated that Resident 4 was noted to be incontinent at the time of the fall. There were two staff witness statements included with the incident report, and both indicated that neither one had witnessed the fall. The investigation and witness statements failed to identify when Resident 4 had last been observed by staff or the last time care had been provided. During an interview with DON on February 26, 2024, at 1:48 PM, she confirmed that the fall had occurred from the bed. She indicated that incontinence care was provided immediately after the fall. She also indicated that the interdisciplinary team had reviewed the fall and had ruled out abuse and neglect. She said that staff document by exception, so it was determined that Resident 4's care plan was being followed at the time of the fall since no other documentation indicated that it was not being followed. She confirmed that the staff witness statements and the investigation did not include when Resident 4 was last observed or incontinence care was provided. She also added that Resident 4 was care planned to remove their socks and/or footwear. Review of Resident 4's care plan revealed that they were care planned at risk for falls, but there was no documentation on the care plan that Resident 4 removes their socks and/or footwear. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident 4's care plan revealed that they were care planned for being incontinent of bowel and bladder, with a revision date of October 21, 2023; and interventions included, but were not limited to, prompt void every two hours, with an initiation date of December 1, 2022. Email communication was sent to DON on February 28, 2024, at 9:51 AM and 11:05 AM, requesting additional information related to Resident 4's fall. Additional information received via email from the DON on February 28, 2024, at 3:57 PM, revealed that she had obtained a statement from the nurse assigned to Resident 4 on February 18, 2024, for day shift. The DON shared that this nurse indicated that she had previously written a statement on the day the fall occurred, but that she (DON) was not able to locate it. Review of this statement indicated that the nurse assigned to Resident 4 on February 18, 2024, had last been in Resident 4's room at 10:25 AM when she administered a nutritional beverage . The nurse further indicated that Resident 4 was in bed with no complaints or needs at that time. The DON also provided a medication administration report that confirmed this nutritional beverage was documented as administered at 10:25 AM. The DON also indicated that the interdisciplinary team verbally discusses each fall in their meeting as they are still collecting the written documentation, such as statements. DON added that when Resident 4's fall was reviewed, the team noted that Resident 4's care plan was being followed since Resident 4's care plan intervention was to encourage proper footwear, not that she should wear them at all times, and that per nursing notes she does have a history of removing non-skid socks. This statement did not include any information regarding when Resident 4 was last toileted or when incontinence care was provided. Email communication was sent to the DON on February 29, 2024, at 1:58 PM, and to the DON and NHA on March 1, 2024 at 2:18 PM, again requesting additional information for Residents 3 and 4 and their fall investigations. Per email communication received from the NHA on March 1, 2024, at 2:28 PM, the NHA indicated that the facility had no other supporting documentation to provide. During an interview with the NHA, Assistant NHA, and DON on March 1, 2024, at 3:14 PM, the NHA confirmed that he would expect thorough investigations to be completed after an incident. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services