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	04/25/2024

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

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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 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. 37116 Based on policy review, observation, and staff interviews, it was determined that the facility failed to ensure that care and services were provided in a manner that enhanced or maintained resident dignity for one of 35 residents observed (Resident 146). Findings include: Review of facility policy, titled Dignity and Respect, revised May 2023, revealed, Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect .Residents shall be treated with dignity and respect at all times. 'Treated with dignity' means the resident shall be assisted in maintaining and enhancing his or her self-esteem and self-worth. Review of Resident 146's clinical record revealed diagnoses that included Alzheimer's disease (gradually progressive brain disorder that causes problems with memory, thinking, and behavior) and major depressive disorder (mental disorder characterized by at least two weeks of low mood that is present across most situations). Observation on April 22, 2024, at 1:45 PM, revealed Resident 146 ambulating in the hallway. Resident 146 was wearing a white knit shirt that was tucked tightly into her pants, pulling the shirt collar down, and causing the shirt to fit closely to her body. It was observed that Resident 146 was not wearing a bra, and her breasts were visible through the shirt. During an interview with Employee 6 (Nurse Aide) on April 22, 2024, at 1:59 PM, she revealed that when she dressed Resident 146 that day, Resident 146's bra had the prongs sticking out so she did not put it on, and the white knit shirt was the only one Employee 6 could find. Employee 6 stated that, in her experience, Resident 146 does not refuse to wear a bra. Employee 6 then requested that Employee 10 (Nurse Aide Trainee) go to Resident 146's room and attempt to find an additional article of clothing to cover Resident 146. During an interview with the Director of Nursing on April 25, 2024, at 10:02 AM, she agreed that Resident 146 should have been dressed in a way that prevented her from being exposed. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(2)(3) Management (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1) Nursing services

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 48484 Based on clinical record review, observations, and staff interview, it was determined that the facility failed to ensure that resident needs were accommodated regarding call bell accessibility for two of 35 residents reviewed (Residents 39 and 271). Findings include: Review of Resident 39's clinical record revealed diagnoses that included morbid obesity (a complex disease involving having too much body fat, which increases the risk of many other health problems), difficulty in walking, and muscle weakness. Observation in Resident 39's room on April 22, 2024, at 12:46 PM, revealed she was in bed during lunchtime and her call bell was on the floor. Observation in Resident 39's room on April 22, 2024, at 1:49 PM, revealed she was finished with lunch, her lunch tray was gone, and her call bell remained in the same place on the floor. Review of Resident 39's care plan on April 22, 2024, revealed a focus area of: [Resident 39] is at risk for falls related to new and unfamiliar environment, deconditioning (changes in the body that occur during a period of inactivity), and weakness, last revised February 20, 2024, with an intervention for be sure that the call bell and personal items are in reach before leaving the room, initiated June 1, 2022. Review of Resident 271's clinical record revealed diagnoses that included muscle weakness and difficulty in walking. Observation of Resident 271 in his room on April 22, 2024, at 12:46 PM, revealed he was up in his wheelchair yelling out I need to go to the bathroom urgently, and his call bell was lying across his bedside table behind him, out of reach. Observation of Resident 271 in his room on April 24, 2024, at 9:59 AM, revealed he was up in his wheelchair and said, I need to go to the bathroom. Further observation in Resident 271's room on April 24, 2024, at 9:59 AM, revealed his call bell was clipped to his bed behind his wheelchair out of reach. Review of Resident 271's care plan revealed a focus area of: [Resident 271] is at risk for falls related to new and unfamiliar environment, deconditioning, and weakness, last revised May 2, 2022, with an intervention for be sure that the call bell and personal items are in reach before leaving the room, last revised November 20, 2022. Interview with the Nursing Home Administrator on April 24, 2024, at 2:09 PM, revealed he would expect residents to have access to their call bells. 28 Pa code 201.29(a) - Resident Rights (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa Code 211.12(d)(1) Nursing Services

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 40010 Based on observation, facility policy review, clinical record review, and staff interview, it was determined that the facility failed to provide the resident personal privacy during medical treatment for one of 38 residents reviewed (Resident 93). Findings Include: Review of facility policy, titled Dignity and Respect, last reviewed May 2023, revealed, Staff shall maintain an environment in which confidential clinical information is protected. Review of Resident 93's clinical record revealed diagnoses that included peripheral artery disease (a vascular disorder that causes arteries to narrow abnormally, reducing blood flow to the limbs) and cerebrovascular disease (a group of conditions that affect blood flow and the blood vessels in the brain). Observation of Resident 93 on April 22, 2024, at 1:34 PM, revealed Resident 93 sitting in her wheelchair in the middle of the hallway with five other residents in the hallway. Employee 5 approached Resident 93 in the hallway and notified her that, as a result of a recent consultation, they were recommending that Resident 93 have an above the knee amputation of her right leg. The Resident started to cry, and then wheeled herself back to her room. When approached, Resident 93 stated that she just wanted to be left alone and asked the surveyor to leave. Review of Resident 93's care plan on April 23, 2024, revealed a care plan with a focus area of: Resident 93 may display signs of sadness/depression related to vascular disease and possible need for amputation, initiated on April 23, 2024. Staff interview with the Director of Nursing on April 23, 2024, at 9:35 AM, revealed that she would expect the Resident's medical information be kept confidential, and that her care plan was revised to identify her sadness/depression with regards to her condition. 28 Pa Code 211.5(b) Medical Records

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 33305 Based on observations and resident and staff interviews, it was determined that the facility failed to maintain a safe, clean, comfortable, and home-like environment for two of 35 residents observed (Residents 220 and 258). Findings include: Observation on April 22, 2024, at 12:11 PM, revealed that Resident 220's bilateral wheelchair armrests had vinyl covering that was cracked and torn away on the sides. Further observation revealed the foam stuffing was protruding from both armrests. An immediate interview with Resident 220 revealed that she utilizes the wheelchair every day for mobility, and that the wheelchair belonged to the facility. During an interview with the Nursing Home Administrator (NHA) on April 25, 2024, at 10:53 AM, the NHA stated that maintenance and therapy personnel are assessing the wheelchair at that time to determine replacement and repair. During an interview with the NHA on April 25, 2024, at 11:51 AM, the NHA stated that the facility performs periodic inspections, but this wheelchair was not observed, and acknowledged the wheelchair armrests will be replaced or repaired. Observations on April 22, 2024, at 10:31 AM, and on April 24, 2024, at 10:25 AM, revealed that Resident 258's overbed table was missing a piece of trim around the edge, the veneer was damaged, and the inner wood was exposed along one end of the table. During an interview with the NHA on April 25, 2024, at 10:00 AM, he revealed that maintenance replaced Resident 258's overbed table. During a later interview at 11:33 AM, the NHA revealed that he looked at the table that had been removed and acknowledged that it should have been replaced. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 33879 Based on policy review, clinical record review, and resident and staff interviews, it was determined that the facility failed to develop and implement a comprehensive person-centered plan of care for three of 35 residents reviewed (Residents 220, 291, and 317). Findings Include: Review of the facility's policy, titled Care Planning Process and Care Conference, revised July 2023, read, in part, the facility will develop a comprehensive, resident centered care plan for each resident/patient. Care plan development, renewal and revision will be based upon the results of the resident assessment. The care plan is a working tool that provides a profile of the needs of the individual resident/patient; the resident/patient care plan will be available for use by staff caring for the resident. Review of Resident 220's clinical record revealed diagnoses that included muscle weakness and portal vein thrombosis (a narrowing or blockage of the portal vein by a blood clot). Review of Resident 220's physcian's orders revealed the medication Eliquis prescribed two times per day for thrombosis, dated October 18, 2023. Eliquis is a prescription medicine used to reduce the risk of stroke and blood clots. Review of Resident 220's interdisciplinary plan of care revealed none developed to address Resident 220's use of the medication. An interview with the Director of Nursing (DON) on April 25, 2024, at 10:06 AM, revealed an acknowledgement of the lack of the care plan and provided an updated care plan addressing Resident 220's use of the medication. Review of Resident 291's clinical record documented diagnoses that included hemiplegia left non-dominant side following cerebral infarction (partial paralysis after a stroke). During an interview with Resident 291 on April 22, 2024 it was confirmed that he chooses to smoke, there are scheduled smoking times, and that he has no concerns regarding his preference to smoke. Review of Resident 291's care plan on April 22, 2024, failed to document that the Resident had a preference to smoke. Further review of Resident 291 care plan on April 24, 2024, documented a focus area for Resident is a smoker, who wishes to continue smoking related to not wishing to quit smoking, date initiated April 23, 2024. During an interview with the DON on April 24, 2024, at 1:50 PM, it was revealed that Resident 291 should've had a smoking care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 317's clinical record documented diagnoses that included congestive heart failure (CHF - the heart doesn't pump blood the way it should), shortness of breath, and chronic kidney disease (CKD - the kidney doesn't function as it should). Interview with Resident 317 on April 22, 2024, at 11:07 AM, revealed that his left hearing aid wasn't working, and his right hearing aid was working at forty percent. Resident 317 explained that someone looked at them several months ago, but had not heard anything since that time. It was further revealed that his hearing had gotten significantly worse over the past year. Review of Resident 317's care plan on April 23, 2024, failed to document that Resident 317 was hard of hearing or utilized hearing aids. Further review of Resident 317's care plan on April 24, 2024, revealed a focus area for at risk of having a communication problem related to minimal hearing deficit, bilateral hearing aids, date Initiated April 24, 2024. During an interview with the DON on April 24, 2024, at 1:50 PM, it was revealed that resident 317 should've had a care plan for hearing loss and use of hearing aids. 28 Pa. Code 211.12(d) Nursing Services

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 33879 Based on clinical record review, facility document review, and staff interview, it was determined that facility failed to provide an appropriate rationale to a pharmacy recommendation, resulting in the continuance of an antipsychotic medication for indications that were not present, for one of five residents reviewed for unnecessary medications (Resident 224). Findings include: Review of Resident 224's clinical record, revealed diagnoses that included unspecified dementia (irreversible, progressive degenerative disease of the brain that results in decreased reality awareness and decreased ability to perform activities of daily living) unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and major depressive disorder (condition of persistently low mood, that may include symptoms of decrease interest in pleasurable activities, lack of energy, and/or sleep disturbance). Review of Resident 224's clinical record revealed that on November 14, 2023, Hospice services ordered the addition of Seroquel (antipsychotic medication used to treat symptoms of psychosis associated with, but not limited to, schizophrenia or bipolar disorder - delusions, hallucinations, false beliefs) 25 milligrams (mg - metric unit of measure) to be taken at bedtime for anxiety and restlessness. Review of Resident 224's clinical record revealed that the Hospice order for Seroquel 25 mg at bedtime was accepted by the facility's physician and started on November 15, 2023, with an indication for use of anxiety/restlessness. Review of a pharmacy medication review recommendation dated December 12, 2023, revealed the consultant pharmacist made the recommendation of, Please include an appropriate diagnosis for the Seroquel order. This medication is typically used in the treatment of bipolar disorder and schizophrenia. If appropriate, please update the indication to this more specific, [Food and Drug Administration] approved indication . Review of the response to the recommendation revealed that on December 19, 2023, the facility provider declined the recommendation and responded for the Resident to continue to have the medication due to behaviors and diagnosis of dementia with behaviors and psychosis. Review of Resident 224's behavior monitoring contained with the Medication Administration Record and the interdisciplinary notes revealed that staff had not documented any occurrence of behaviors or psychosis during the months of November 2023 and December 2023. Review of Resident 224's clinical revealed that the pharmacy provider did not further question the appropriateness of the Seroquel medication for indications that were not documented in Resident 224's clinical record. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 224's physician orders revealed that on April 23, 2024, the Seroquel order was reordered at the same dose and time, but with an indication of psychosis, agitation, and anxiety. Further review of Resident 224's clinical record revealed no indication that Resident 224 was experiencing any symptoms of psychosis prior to the change in indication for the medication. During a staff interview on April 25, 2024, at approximately 12:00 PM, Director of Nursing revealed that the facility was actively reviewing the facility's application of psychotropic medications; however, had no further information to provide regarding Resident 224's medication regimen review. 28 Pa code 211.2(d)(9) Medical director 28 Pa code 211.9(k) Pharmacy services

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 33879 Based on facility policy review, clinical record review, facility document review, and staff interviews, it was determined that the facility failed to ensure resident medication regimens were free from unnecessary psychotropic medication for one of five residents reviewed for unnecessary medications (Resident 224). Findings include: Review of facility policy, titled Psychotropic Medication Use, Including Use in Dementia Residents, last reviewed March, 2024, revealed the policy stated, Based on a comprehensive assessment of a resident the Facility will ensure that residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the medical record . Psychotropic medications will be prescribed at the lowest possible dosage for the shortest duration of time to effectively treat the target mood/behavior; they are subject to gradual dose reduction, unless clinically contraindicated, and re-reviewed .Antipsychotic medications may be prescribed for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed. The policy's Procedure section stated, 1. Residents will only receive psychotropic medications when necessary to treat specific conditions for which they are indicated and effective. 2. The Attending Physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. An informed consent/risks and benefits will be reviewed with the resident representative and resident (if appropriate). 3. The Attending Physician in conjunction with the Psychiatrist if applicable, will identify, accurately Assess/diagnose and document, with input from other disciplines and consultants as needed, Symptoms that warrant the use of psychotropic medications .Accurate Assessment/diagnosis of schizophrenia is necessary to avoid inaccurate use of unnecessarily Prescribing of antipsychotic medications . 7. Diagnoses alone do not warrant the use of antipsychotic medication .antipsychotic medications will generally only be considered if the following conditions are also met; a. The behavior symptoms present a danger to the resident or others; AND: b. The symptoms are identified as being due to mania or psychosis (such as auditory, Visual, or other hallucinations; delusions, paranoia or grandiosity); or aggressive Behavior (hitting, kicking or biting) and: c. Behavioral interventions have been attempted and included in the plan of care, except In an emergency . 8. Antipsychotic medications will not be used to treat the following behaviors unless behaviors Present as a danger to self or others: .b. Poor self-care, c. Being restless- when it's hard for a person to sit still .e. Mild anxiety; f. Insomnia .l. Uncooperativeness (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11. The staff will observe, document, and report to the Attending Physician information regarding The effectiveness/ineffectiveness of any interventions. 13. Nursing staff shall monitor and report [sic] side effects and Adverse Consequences of psychotropic medications to the Attending Physician . Review of Resident 224's clinical record revealed diagnoses that included unspecified dementia (irreversible, progressive degenerative disease of the brain that results in decreased reality awareness and decreased ability to perform activities of daily living), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and major depressive disorder (condition of persistently low mood, that may include symptoms of decrease interest in pleasurable activities, lack of energy, and/or sleep disturbance). Review of Resident 224's clinical record revealed that on November 14, 2023, Hospice services ordered the addition of Seroquel (antipsychotic medication used to treat symptoms of psychosis associated with, but not limited to, schizophrenia or bipolar disorder - delusions, hallucinations, false beliefs) 25 milligrams (mg - metric unit of measure) to be taken at bedtime for anxiety and restlessness. Review of Resident 224's clinical record revealed that the Hospice order for Seroquel 25 mg at bedtime was accepted by the facility's physician and started on November 15, 2023, with an indication for use of anxiety/restlessness. Review of Resident 224's clinical record revealed that, at the time of the addition of Seroquel, Resident 224 was already ordered one medication, Buspar (antianxiety medication) routinely twice a day for anxiety, and one medication, Ativan (antianxiety medication) on an as-needed basis for agitation. Review of Resident 224's Medication Administration Record (MAR - Documentation tool utilized to record when a medication has been administered) revealed that staff administered the Ativan twice in October, 2023, and the administration was found to be effective towards agitation symptoms. During the month of November 2023, leading up to November 15, 2023, Resident 224 did not receive the as needed Ativan. Review of the MAR for the months of October 2023, November 2023, and December 2023, revealed no documented incidents of anxious behaviors. Review of Resident 224's interdisciplinary notes for the months of October 2023, November 2023, and December 2023, revealed that at no time did staff document any negative behaviors or psychotic symptoms demonstrated by Resident 224. Prior to the order for the antipsychotic medication, Seroquel, on November 15, 2023, Resident 224 displayed no behavioral and psychological symptoms that justified the use of the antipsychotic medication. Further review of the clinical record revealed that no symptoms or justification were provided by the hospice or attending physician for the use of an antipsychotic medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a progress note entered on December 19, 2023, revealed it stated, Pharmacy recommend to change [diagnosis for Seroquel]. [Diagnosis] changed to Dementia with behavioral disturbance and psychosis. Review of clinical records for Resident 224 for October 2023, November 2023, and December 2023, revealed Resident 224 had no documented signs or symptoms of psychosis, such as false beliefs, delusions, and/or hallucinations. Review of Resident 224's clinical record revealed no screening or assessment for side effects of an antipsychotic medications were in place during the duration of the Seroquel use from November 15, 2023, to April 23, 2024, for side effects specific to antipsychotic medications. Review of Resident 224's comprehensive plan of care revealed no care plan for the use of an antipsychotic medication, monitoring of target behaviors, and/or antipsychotic medication side effect monitoring. Review of clinical document, titled Informed Consent for Psychotropic Administration Form, revealed that the documented discussion of risks versus benefits of the medications was not conducted until March 8, 2024, almost five months after the start of the antipsychotic medication. During a staff interview on April 25, 2024, Director of Nursing revealed the facility had no further information or documentation to provide regarding the use of an antipsychotic medication for Resident 224. 28 Pa code 201.18(b)(1) Management 28 Pa code 211.2(d)(3) Medical director 28 Pa code 211.12(d)(1)(3)(5) Nursing services

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 48484 Based on select facility document review, clinical record review, observations, and staff interviews, it was determined the facility failed to ensure the menu was followed at one of one meal observed, and failed to ensure residents on therapeutic diets needs were met for two of 52 residents observed (Residents 121 and 338). Findings include: Review of the menu extension sheet for the lunch meal on April 24, 2024, revealed residents that ordered the main meal on the regular diet should be served Italian sausage with peppers and onions as their entree. Observation in the main kitchen during tray line meal service on April 24, 2024, between 11:59 AM and 1:15 PM, failed to reveal onions and peppers being served with the Italian sausage for the main meal. Interview with Employee 2 (Dietary Manager) on April 24, 2024, at 1:25 PM, revealed she was working in the back of the kitchen during meal service, and she will follow-up about the onions and peppers not being served. During an interview with the Nursing Home Administrator (NHA) on April 24, 2024, at 2:18 PM, the surveyor revealed the concern with the peppers and onions not being served at lunch service. Follow-up interview with Employee 1 (Assistant NHA) on April 25, 2024, at 11:00 AM, revealed she verified that the peppers and onions were on the dietary production sheets for the lunch meal the day prior, and the production sheets should have been followed. Review of Resident 121's clinical record revealed diagnoses that included cerebral infarction (occurs when the blood supply to part of the brain is blocked or reduced), dysphagia (difficulty swallowing), and iron deficiency anemia (a condition where the blood lacks adequate healthy blood cells due to insufficient iron). Review of Resident 121's physician orders revealed an order for Regular diet Pureed texture, Honey Thick Liquids consistency, Double portions, with a start date of May 1, 2023. Review of Resident 121's care plan revealed a nutrition care plan focus area that notated he has a history of gradual weight loss and is ordered a therapeutic diet. Observation during tray line meal service on April 24, 2024, at 12:15 PM, revealed Resident 121's meal ticket noted he should be served double portions, however, double portions were not served. (continued on next page)

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	04/25/2024

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

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 338's clinical record revealed diagnoses that included Gastroesophageal reflux disease (occurs when stomach acid repeatedly flows back into the tube connecting your mouth and stomach) and Chronic obstructive pulmonary disease (COPD - a group of lung disease that block airflow and make it difficult to breathe) Review of Resident 338's physician orders revealed an order for Regular diet Mechanical Soft - Chopped texture, Regular/ Thin Liquids consistency, Double portions, with a start date of April 17, 2024. Review of Resident 338's care plan revealed a nutrition care plan focus area that notated he has a history of weight loss and was ordered a therapeutic diet. Observation during tray line meal service on April 24, 2024, at 1:10 PM, revealed Resident 338's meal ticket noted he should be served double portions, however, double portions were not served. During an interview with the NHA on April 24, 2024, at 2:18 PM, the surveyor revealed the concern with the therapeutic diets for the two aforementioned residents not being provided at lunch service. No further information was provided. 201.14. Responsibility of licensee (a)

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	04/25/2024

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 48484 Based on menu extension sheet review, observations, and staff interviews, it was determined the facility failed to ensure residents were served food prepared in a form designed to meet their individual needs for 13 of 52 residents observed at one of one meals observed (Residents 17, 43, 81, 90, 97, 111, 165, 170, 188, 193, 220, 311, and 338). Findings include: Review of the menu extension sheet for the lunch meal on April 24, 2024, revealed residents who are on the chopped texture diet should be served four ounces of pastina pasta instead of bowtie pasta. Observation in the main kitchen during tray line meal service on April 24, 2024, between 11:59 AM and 1:15 PM, revealed the tray tickets for Residents 17, 43, 81, 90, 97, 111, 165, 170, 188, 193, 195, 220, 311, and 338 notated they were ordered a chopped diet texture and should be served the pastina pasta instead of bowtie pasta. Further observation in the main kitchen during tray line meal service on April 24, 2024, between 11:59 AM and 1:15 PM, revealed Residents 17, 43, 81, 90, 97, 111, 165, 170, 188, 193, 195, 220, 311, and 338 were served regular bowtie pasta instead of the pastina pasta. During an interview with Employee 2 (Dietary Manager) on April 24, 2024, at 1:25 PM, the surveyor revealed the concern of the 13 residents on the chopped diet were not served the pastina. Employee 2 revealed the aforementioned residents should have been served the pastina pasta instead of bowtie pasta. During an interview with the Nursing Home Administrator on April 24, 2024, at 2:18 PM, the surveyor revealed the concern with bowtie pasta served to the aforementioned residents instead of the pastina pasta at the lunch meal service. No further information was provided. 201.14. Responsibility of licensee. (a)

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	04/25/2024

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

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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 - Few	Provide and implement an infection prevention and control program. 33879 Based on observations, policy review, and staff interview, it was determined that the facility failed to follow infection control standards for two of five residents observed for medication administration (Residents 93 and 281). Findings include: Review of facility policy, titled Medication Administration/Disposition, last reviewed June, 2023, revealed that subsection 21 of Procedures, stated, Staff shall follow established facility infection control procedures (e.g., hand hygiene, gloves, [i]solation precautions, etc) for the administration of medications prior to and after medication [a]dministration. During medication administration observations on April 25, 2024, at approximately 8:52 AM, Employee 7 was observed preparing medications for administration to Resident 281. During preparation of the medications, Employee 7 was observed dispensing one tablet of vitamin D 25 micrograms (mcg - metric unit of measure) from a multidose container into her bare hand. Employee 7 then placed the tablet from her hand into a medicine cup. Employee 7 then completed preparation of medications and administered the vitamin D tablet to Resident 281. During medication administration observations on April 25, 2024, at approximately 9:00 AM, Employee 7 was observed preparing medications for administration to Resident 93. During the preparation of medications, Employee 7 was observed dispensing two tablets of vitamin B12 500 mcg, two tablets of Senna S 8.6/50 milligrams (mg - metric unit of measure), and one multivitamin tablet from a multidose container into her bare hand, and then into a medicine cup. Employee 7 then completed preparation of medication and administered the aforementioned medications to Resident 93. During a staff interview on April 25, 2024, at approximately 10:00 AM, the Director of Nursing revealed that staff should not handle medications with their bare hands. 28 Pa code 211.12(d)(1)(3)(5) Nursing services